Am. 86 Gubut Gurevitch

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examples must be notified at

is marked other than

permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic event bhose.

Physician

Examiner

2

signed by

Door

certificate has page 2

Alter this funeral

SW.

2

Attending

after death Director:

To the Hospital of within 24 hours a To the Funeral D

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Box 68760

Records, P.O.

Division of Vital Physician:

/Medical

the Maryland

death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 3. Tima of Death 1. Decedent's Neme (First, Middle, Lest) JULY 8, 1998 **Physician** GUREVITCH ROBERT 11:26 AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not Institution, give street and number) Examiner TOWSON BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CENTER If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) if Under 1 Year Birthplece (State or Foreign Country) 5. Social Sacurity Number 6 Sex XXX 2 F Months Deys Hours Yrs. OCT.20,1911 109-12-1877 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 Yes 3(XNo Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10a, Citizen of Whet Country? 7 SLADE AVENUE #304 21208 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1♥1 Yes 2 □ No If Yes, Give Yaar or Dates: WWII 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Black, Whita, etc. 1 Never Married Marrie 1 1 ☐ Yes 2 No Specify: Specify WHITE WWII by 3 Widowed 4 Divorcad Completed Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coltege (1-4or 5+) PHARMACIST MEDICINE 18. Mother's Neme (First, Middle, Maiden Sumema) 17. Father's Name (First, Middle, List) MOGEN **ISADORE** GUREVITCH MARY 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) FANNIE GUREVITCH (WIFE) 7 SLADE AVE. #304 BALTIMORE, MD 21208 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State Muriel 2 Cremetion 3 Remove from State KING DAVID MEMORIAL GARDENS 7/9/98 FALLS CHURCH, VA 4 ☐ Donetion 5 ☐ Other (Sp ∋cify) 22. Nama end Address of Fecility SOL LEVINSON & BROS., INC. 21. Signeture of Funerel Servica L censes MD 21208 8900 REISTERSTOWN ROAD PIKESVILLE, orce Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one cause on each line. Approximete Intervst Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lymphoma 4 Years Due to (or es e consequence of): Examine Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or trijury that initieted events resulting in deeth) Lest Due to (or es e consequença of): Physician/Medical Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of desth? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 25 No þ 24b. Were sutopsy findings aveilable prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? 1 ☐ Yas 2 ☐ No 25. Wes case referred to medica exeminer? 88 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: 10 1 ☐ Yas 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA 28d. Describe how triury occurred 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury st Work? Certification: 1* Neturai 5 ☐ Pendir a 1 Yes 2 No investi jation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide edical 29e. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and menner stated. (Check only one) 29d. Deta signed (Month, Dey, Year) 29c. Licensa number 29b. Signature and little of certifier July 8, 1998 who completed cause of death (Item 23s) (Type, Print) 6701 N. Charles St. BALTO. Md. 21208 6BMC 32. Registrar's Signature

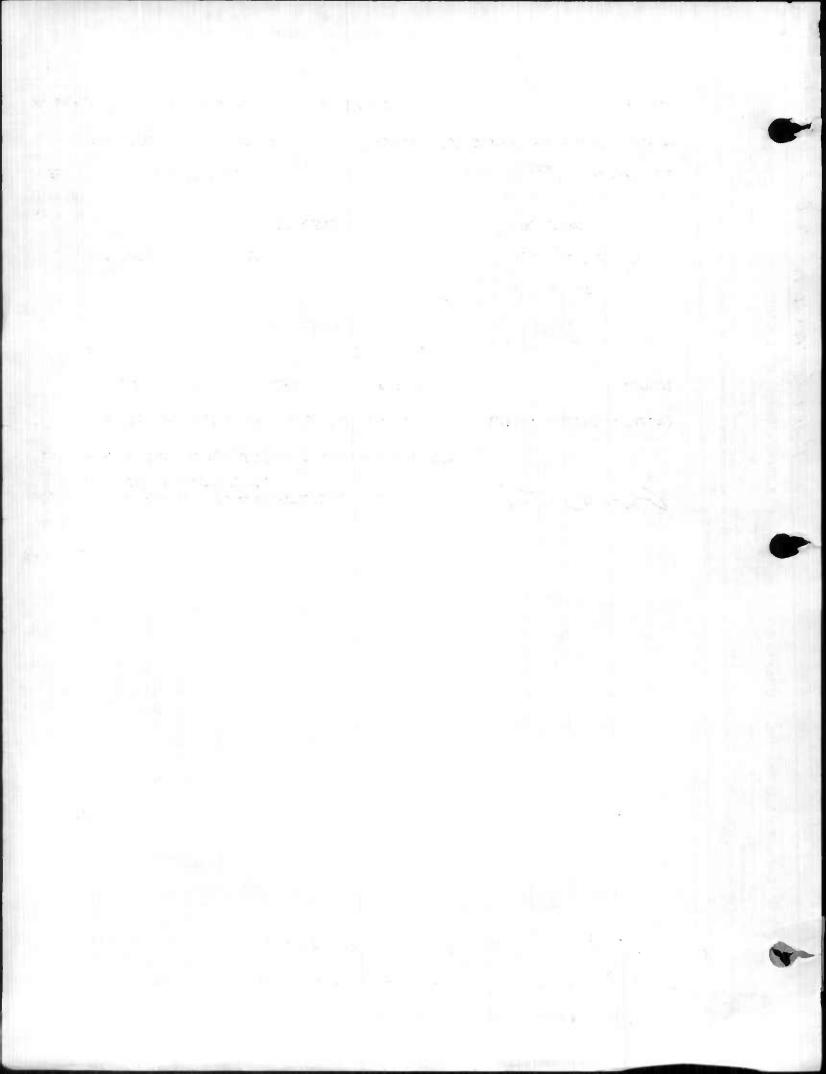
who Davidson

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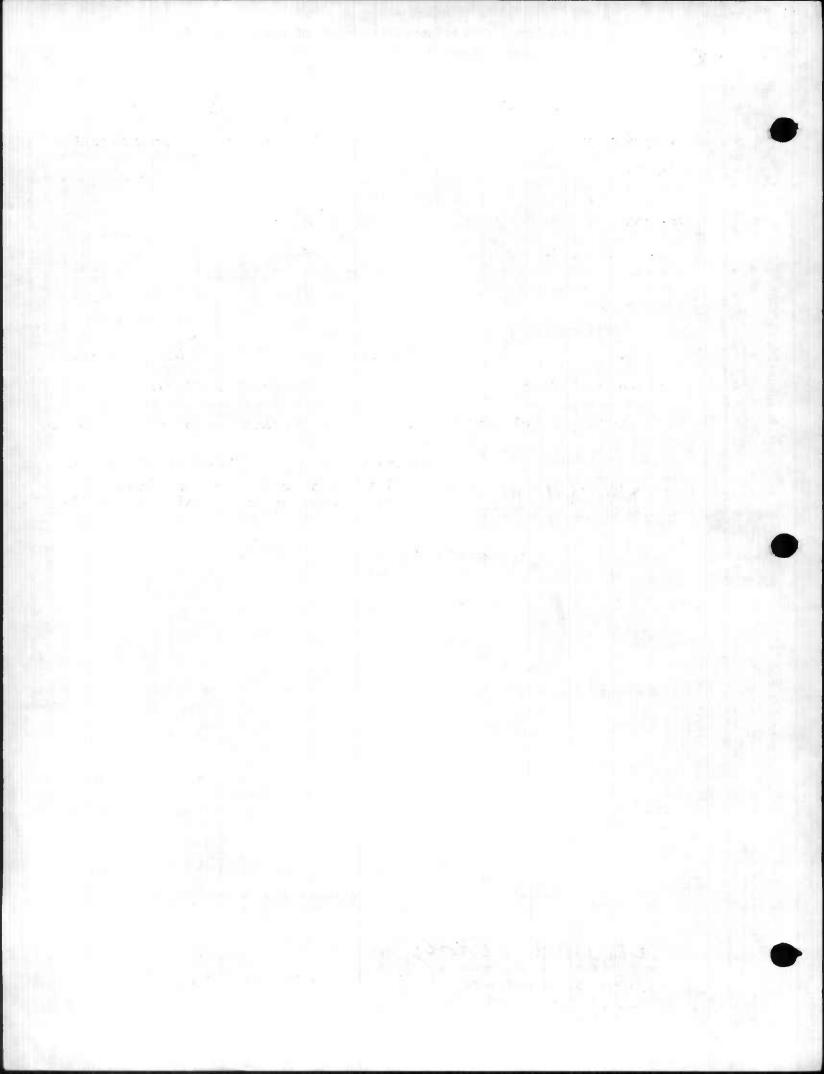
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MA

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_	ITEMS: #23	PART I, 27, 28A-F PE		-98 WR. Cei	rtificate of	Death	7		eg. No.	6.0	1002
П	Physician	Decedent's Name (First, Middle,		TT 1				2. Date of Deat Month	Day	Yaar	3. Time of Death 11:00am
	/Medical	4a Facility Name (If not institution,	Mark James	nullt		4b. City. T	own, or Lo	JULY cation of Death	10, 1998		II.ooaiii
ŀ	Examiner	MARLEY CREEK	giva stroot and numbery				BURI		ANNE		IDET.
	Funeral			In yrs. last birthday)	If Undar 1 Year	If Unde	r 24 Hrs.	8. Date of Birth			laca (Stete or Foreign try)
Ł,	Director	579-70-3387	40 M 2□ F	46 Yrs.	Months Days	Hours	Min.	AUG. 17	1951	Oh	10
	Pu .	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation					1	0d. fnside City Limits
	Aaryle ed a	2000		oo. ony, rount of Lo		D					1 ☐ Yes ŽĎ No
	or 28a-f	Maryland Anne	Ar under		Glen 10f. Zip Code	buri	116	1	Og. Citizen of W	/hat Coun	itry?
	3a or	117 Louise	Terrace		21	060			USA	A	
	ther death v	11. Marital Status	12. Was Decedent Eve Armed Forces?	ar In U,S. 13.	Was Decedent of I	Hispanic O	rigin? (Spe	ecify Yes or No-	14. Race		en Indian,
50		1 Never Married 2 Married	1 ☐ Yes 2 No		1 ☐ Yas 2X No			ritori, ato.,	Specify		ite
000	uraf, o	3 ☐ Widowad 4 ☐ Divorced	Year or Dates:					1			
21215-0020	led within 72 ho ygiene. Yer than "nature It, the Wed call	15. Decedent's (Specify only highest)	grade completed)	(Give	dent's Usual Occu kind of work dona DO NOT use retire	pation during mo id)	st of work	ing	16b. Kind of Bu	SINESS/INC	dustry
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D	tal Hyg d other event,	17. Fathar's Name (First, Middle, Le	est)			18. Moth	her's Name	(First, Middla, I			
yla	should be and Mental and Mental or umeric eve	Lloyd Darl H	Hulit			Sar	cah l	Ellen 1	Taylor		
Maryland	2 should be and is marked in a	19a. Informant's Name/Relationship			ng Address (Stree						
_	as 1 and of Health item 27 other to	Lisa Stephanie	Hulit/wi	20b. Place of Dispo		Ter	crace		Burn:		MD 21060
nor	65 0 6-	1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spe	Removal from State	cemetery, crei	metory or other ple						
altimore,	교원관금 .	21. Signature of Funeral Service Lie	рапыры 🔿	2:	ematory, 2. Name and Address	ess of Feci	ility				,
ä	Depa Impo any i	waund.	11 Honal	N	rematic	on Sc	ocie				
		23e. Part1. Enter the disease, or x shock, or heart feliure. List or	omplications that caused the	e death. Do not en	99 Fred ter the mode of dy	ing, such a	s cerdiac	or respiretory error	LLLIMOI est,	re,	MD 21228 Approximate Interval Between
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F.	/Medical Examiner	Immediate Cause (Final disaasa or condition resulting in death)	a. DROW	NING							
		resulting in death)	Du	ue to (or as a conse	quence of):						
	axecuted in and ial-transit Examiner		b	ue to (or as a consec						<u> </u>	
oʻ	an an an inal-tri	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury		20 10 (01 83 8 001301	querice ory.						
8760,	eath certificate be axecuted attending physician and for use as the burial-transit clan/Medical Examir	Ceuse (Disease or injury that initiated events resulting in death) Last	c. Du	e to (or as a consec	quence of):						
9	ding p		d .								
Вох	at the death certific d by the attending p atached for use as Physician/Me										
o.	ras that the devigened by the a libe datached for the by Physic	Part II. Other significant conditions	contributing to death but i	not resulting in the u	inderlying ceuse gi	ven in Par	t I.				the cause of death? bably 4 1 Unknown
	as that igned be be date								20110	00110	Davis Va Cilkinomi
Records,	w requires that the been signed by th should be datache leted by Phys							24a. Was a perfor	n autopsy med?	av	ere autopsy findings allable prior to
ecc	aw is b										mpietion of ceuse death?
_	The page							1 X Y	es 2 No	1,5	Yes 2□ No
Vital	Attending Physician: The is of death. ecter: After this certificate haby the funeral director, page iffication: To Be Com	25. Was cese referred to medicel examinar?	Hospital:		Ot	A		h (Check only on			ATT COTTAIN
ō	Physical direction of the control of	XX Yes 2 No 27. Manner of Death	1 LI Inpatient		IL SEL DOA		-	me 5 Reside			AT SCENE
O	th. After a fune	1 □ Natural 5 □ Pending 2 ☑ Accident Investiga	28a. Date of Injury (Month, Dey Y	/98 FOUND 1	A Wo	ork?]Yes 212			DROWNED		
Division of	taf or Attending P rs after death. ef Director: After t ied in by tha funera Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	l be 28e. Place of Injury	- At home, farm, st				28f. Location (St.	treet end Numb	er or Rure	el Route Number,
٥	Cert Cert	7 I Hollidge	building, etc. (<i>эрөспу)</i>				ARUNDEL	COUNTY,	PEA CH	REEK, ANNE
	ne Hospi no 24 houns ne Funer pletely fill edical	(Check only 2 X Medical Ex	Physician: To the best of reminer: On the basis of ex	camination and/or In							
	To the Hospital or Attending Physis within 24 hours after death. To the Funeric Director: After this completely filled in by the funeral director and the funeral director and the funeral director and the funeral director and Completely filled in by the funeral director and funeral Completely filled in	one) 29b. Signature and title of certifie	and menner state	G.	29c. Licen	se number	r	2	9d. Dete signe	d (Month.	Dey, Year)
	F3F8) 1 t . 1.	A 71 -	dr		C.M.E			JULY		1998
	11	30. Name and address of person wh	no completed ceuse of dea	th (Item 23a) (Type.	Print)						
			Radentz		nn Street	t, Ba	ltimo	ore, Mar	yland 2	1201	
	State	31. Date filed (Month, Dey, Year)	32a Bagietrarii	Signature	42						
	Registrar	JUL 141998	grain Da	vidson-Cando							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2:45 P.M **Physician** Mary Virginia Hoerl /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not Institution, give street and number) Examiner If Under 1 Year If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) 301 Hospital Dr. 7. Age (m yrs. last birthday) HRundel 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 97 215-40-6091 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Madical Examiner must be notified at Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" and an injury or other treumatic events. 115 Roosevelt Avenue SW 21061 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☐ Yoo If Yes, Give Year or Dates: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. 1 □ Never Married 2 □ Marrie 1 1 ☐ Yes 2 【No Specity: þ White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Domestic Unk. Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unk. Carson Unk. 19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationsh p (Type, Print) 115 Roosevelt Avenue SW Glen Burnie, MD 21061 Raymond Joseph Hoerl - son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gettysburg National Cemetery 7/16/98 Gettysburg, PA 4 ☐ Donation 5 ☐ Other (Sp эсіfy) 21. Signature of Funaral Service Licensee 22. Name and Address of Facility aux c MacNabb Funeral Home, P.A. Dawn F McDonald 301 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrast. Approximate 28. Interval Between Onset and Death Physician Immediata Causa (Final disease or condition resulting in death) /Medical Viscus ABSOMINAL Examiner Examiner SHOUL physician end s the burial-fransit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es e consequence of): 50 980 for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. detached the signed by to 1 Yes 2 No 3 Probably 4 Unknown p 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 1 Yes 2 No 1 Yas 2 No 25. Was casa refarred to medica examiner? funeral director, Be 28. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 10 2 ER/Outpatient 3D DOA shis 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Natural 2 Accidant 5 Pendir g 1 Yes 2 No Invastigation 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 Division of Vital Records, P.O. Attending Physician: 6

the Maryland

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

that the death certificate be executed death. after deatl 24 hours a Hospital Within 2 To the

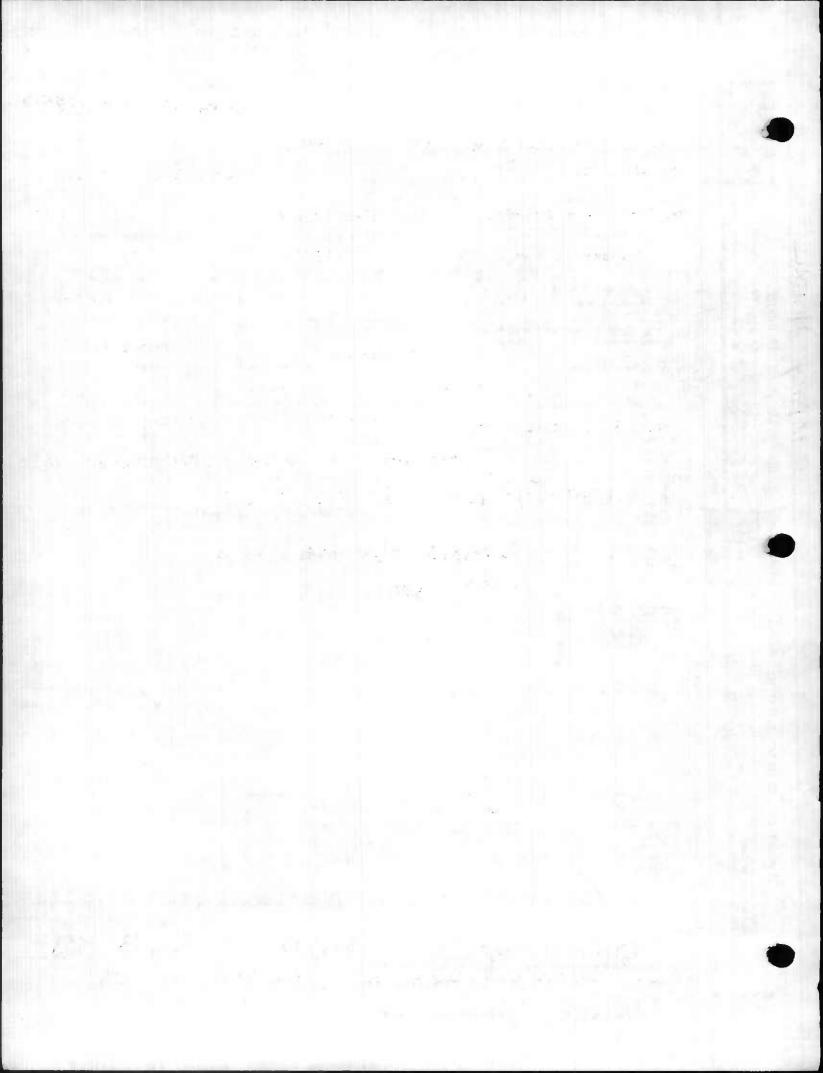
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Cartifying Physician: To the best of my knowledga, death occurred et the time, date and piece, end due to the cause(s) and mainer. On the basis of axamination and/or investigation, in my opinion, daath occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Dete signed (Month, Day, Year)

30. Nama and address of persor who complated cause of death (Itam 23a) (Type, Print)

Oxport DreTun y. 301 Hoth TM Down, Glen Budwie. ms. 21061 31. Delevilled (Month, Day, Year)
JUL 1 4 1998

32. Registrar's Signature Warida



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month 7/8/98 Year **Physician** CORA HENSON 10:03 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not Institution, give street and number) 4c. County of Death **Examiner** 8356 CATHERINE AVE. (HOME) PASADENA A.A. CO. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 9/4/06 If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M #□ F Months Days 215 32 7483 91 Yrs. MD. Director Usuel Residence of Decedent the Maryland 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinet must be notified at 10a State 10h County 10c. City. Town or Location 1 ☐ Yes 2 Ø No Director A.A. CO. **PASADENA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8356 CATHERINE AVE. 21122 permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mentel Hygiane. I important: If item 27 is marked other than "natural", or items 23a and injury or other traumatic event, tra Med all Emerican 2002s. USA Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∰ No If Yes, Give ″ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Merried 2 ☐ Married SpecifyAFRO AMERICAN Baltimore, Maryland 21215-0020 1 ☐ Yes 2 # No Specify: þ 3 # Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highes) grade completed) 18a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC PRIVATE FAMILY 0 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **BERTHA** MILLIKEN HUDSON HUDSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 8356 CATHERINE AVE. PASADENA, MD. 21122 MYRTLE HENSON 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HALL CHURCH CEM. 7/13/98 GLEN BURNIE, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PL. BALTO. MD. 2121

23a. Part1. Enter the disease, or complications that count the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical 1 day Examiner Due to (or es e consequence of) Examiner The law requires that the death cartificeta be executed physician and the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting In death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): ŏ P.O. signed by tha a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cancu Breast Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy peen completion of cause of death? 99 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificete or Attending Physician: funeral director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Aesidence 8 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Aftar 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. invest getion 2 Accident after death Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D complately filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name end address of person who completed cause of death whem 23a) (Type, Print)

. Pegistrar's Signature

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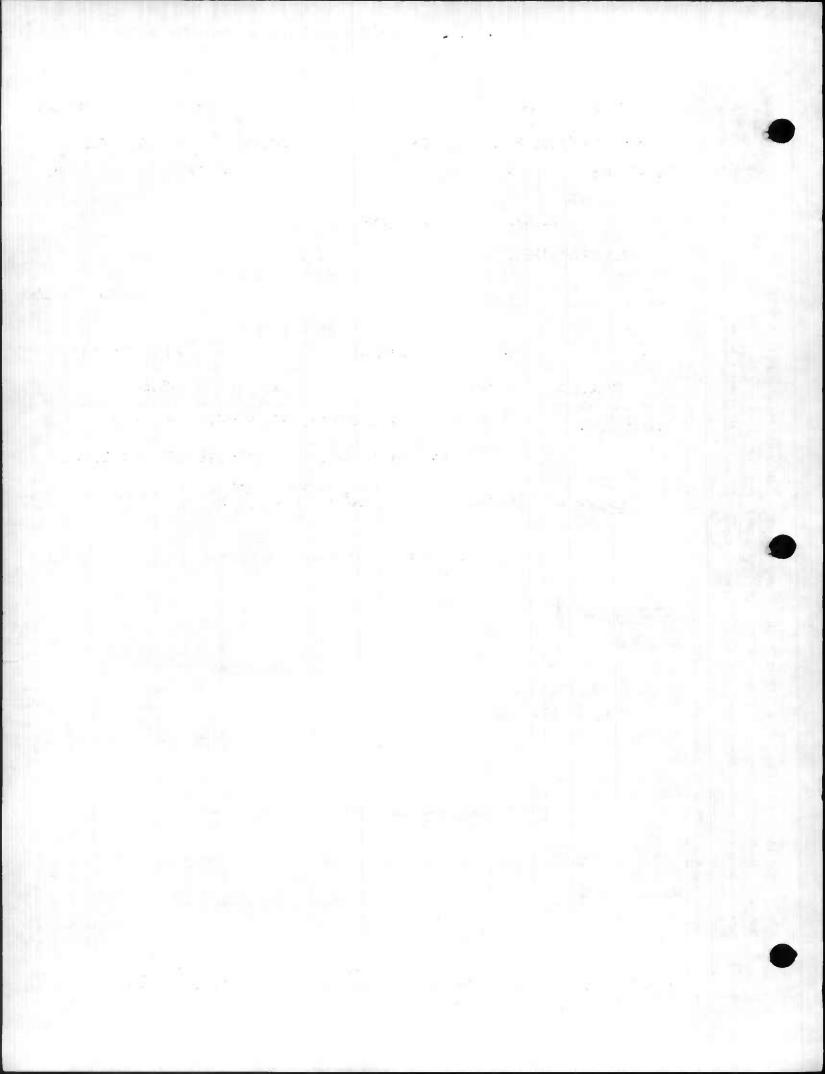
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sant thandel

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State Registrar

31. Date filed (Mo



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Neme	e (First, Middle,	Last)		00,	tificate of	Dout		ate of Deat		W.	3. Time of Death
ysician Medicai	Mary Ros	se Hast		mher)			4b. City, Town	Ju		2, 199 4c. County		3:20 AM
aminer	Genesis E		Part Control		rkwav		Parkvi			Balt		
eral	5. Social Security No. 212-20-03	umber	6. Sex 1 □ M 2 X F	7. Age (<i>In yrs.</i> 75		If Under 1 Year Months Days		Min. (A	ate of Birth donth, Dey, -21-1	923	9. Birthp Court Mary	elace (Stete or Foreig ntry) land
	Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ity, Town or Lo	cation					1	Od. Inside City Limit
rector	Manuland		000		lerton							1 ☐ Yes 2 X N
Lec le	Maryland 10e. Street and Num	nber	ure		Tel coll	10f. Zip Code			11	0g. Citizen of \	What Cour	ntry?
alD	1 Canoga	Place	Apt. TC			21236				U.S.A	•	
by Funeral Director	3 Widowed	ed 2 Merric	Armed Fo	2X No	If	Ves Decedent of I Yes, specify Cub	en, Mexicen, F	? (Specify \ Puerto Rican	(es or No- i, etc.)	Biad	ck, White, White	etc.
Be Completed	(Speci		Education grade completed)	1-4or 5+)	(Give	lent's Usual Occup kind of work done DO NOT use retire	pation during most o	working		16b. Kind of B		dustry
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o Be							Mary	Agnes		vers		
Ĕ	19a. Informant's Na	<u> </u>			19b. Maitin	g Address (Street					Stete, Zip	Code)
To Be Co	Paul S. H	lastman '	n (Son)		1406	Leafy Co	urt Sy	kesvi	lle,	Maryla	nd 2	1784
	20a. Method of Disp		3 □Removal from		Plece of Dispo cem <i>etery</i> , cren	sition (Neme of natory or other ple	ece)	De	te	20c. Location	- City or To	own, State
	4 Donetion			Mor	reland	Memorial	Park	7-15	5-98 E	Baltimo	re, M	Maryland
- DUCE	21. Signature of F	redo	2/2	2_	Du	Name and Address da-Ruck 22 Wise	Funera	Home	of D	Oundalk Maryla	, Inc	1222
an		ntailure. List o	only one ceuse on e	caused the dea each line.	th. Do not ente	er the mode of dyl	Ing, such as ce	rdiac or res	piratory erro	est,	1	Approximata Intervet Between
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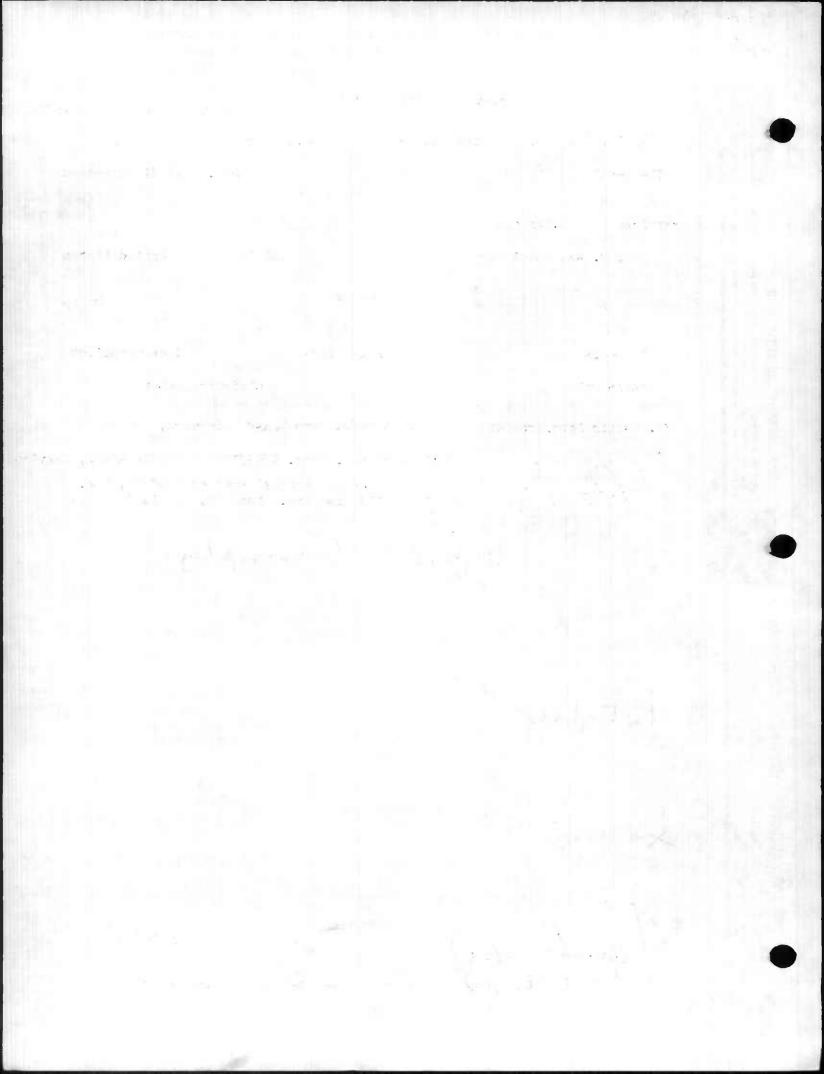
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Certificate of Death	Reg. No.	lug	Û	

				Cer	tificate of	Death	Re	ig. No.	Long	100	0
	Physician	Decedent'a Name (First, Middle, I.a.		Louis	Hahn		2. Date of Deat Month JULY		Year 98	3. Tima of 1231	
).	/Medical Examiner	4a Facility Name (If not institution, giv	re street end number) BAYVIEW MEDICAL	CENT		4b. City, Town, or L	ocation of Death	4c. County		1 1621	FM
	Funeral Director	217-38-9609	Sex 7. Age (in yrs. la: 1⊠ M 2□ F 56	st birthdey) Yrs.	If Under 1 Year Months Days	If Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Aug. 22	Year) 2,1941	9. Birthp Coun	placa (Stete o ntry) yland	r Foreign
	vith the Maryland or 28a-f show be notified at	Usual Residence of Decedent 10a. State 10b. County Maryland Batl	10c. City,	Town or Loc	cation	Edgeme	ere		1	10d. Inside Cit	
	23a or 2 unit be no	10e. Street and Number 2880 G. Natha	aniel Way		10f. Zip Code	212		og. Citizen of V Unit		tates	
020	filed within 72 hours after death with the Maryland thygiena. ther than "natural", or items 23a or 28a-f show one, the Magical Example must be notified at or, the Magical Example must be notified at example Tuneral Director.	11. Marital Status 1 □ Navar Married 2 □ Married 3 □ Widowed 4 ☆ Divorced	12. Was Decedent Evar in U,S. Armed Forces? 1 □ Yes 2 ☒No If Yas, Give Year or Dates:	lf	Vas Decedent of H Yes, specify Cub ☐ Yes 2 X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yas or No- Rican, etc.)		ck, White,	can Indian, etc. White	
21215-0020	an "nature an "nature Medical	15. Decedent's E. (Specify only highest are Elementary/Secondary (0-12)	ducation ede completed) College (1-4or 5+)	(Give I life. D	OO NOT use retire	during most of world)	sing	16b. Kind of Bu			
Maryland 21	void be filed within 72 hos Mental Hygiena. Interest other than "nature afte avent, the Medical To Be Completed	12 Years 17. Father's Name (First, Middle, List) Anton Hahn)	T	ruck Dri	18. Mother's Nam	e (First, Middle, A			tion	
2	should I nd Meni marke umarke	19e. Informant's Name/Reletionship (Z 0-i-4	40h 44-111-		end Number or Ru			Ctata Zia	Code	
altimore, Ma	it. Pages 1 and 2 rtment of Health a rtant: if itsm 27 is njury or other trai	Mr. Martin Hahn 20a. Method of Disposition 1 Buriai 2 Cremation (1 4 Donation 5 Other (Specification of Futural Service Licery)	/Brother 20b. Place	2858 ce of Dispos netery, crem	B Lodge E sition (Name of netory or other ple 1 Mem. C	Carm Road	Edgeme Date 2	ere, MD 20c. Location - Middle	212 City or To	219 own, State er, Ma	rylan
Ba	Depa Depa Impo any II	· Tatul	W. Hemis	7	7922 Wise	ess of Facility Funeral Ave. Du	undalk, I	Marylan		nc. 1222	
}	/Medical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Hyper to for a	try	. ^	nlionz			1	Interval Bett Onsat and I	
ox 68760,	asth certificate be executed attending physician and for use as the bunal-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disease or Injury that Initiated events resulting in death) Last	c	as a consequ							
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	Tha is page page						10 Ye	s 2 No	1/	Yes 2	No
Viita	ysician: The secretificate director, page Co	25. Wes case referred to medical examiner?				26. Place of Dea	th (Check only on	e)		1	
on of V	hya his	27. Manner of Death 1 Tratural 5 Pending 2 Accident investigation	(Month, Dey Year)	R/Outpatient 8b. Time of Injury	28c. Inju		ome 5 Reside		-	6)	
Divis	or And	3 Suicida 6 Could not b	e 20a Blace of laine. At hom	ne, farm, stre	eet, factory, offica		28f. Location (St City or Town		er or Rura	al Route Num	ber,
100	Hope 24 Po Funda Heal	29a. Certifler Conscious Medical Example Conscious Medical Example Conscious	ysician: To the best of my knowl niner: On the basis of examinetio and mannar stated.	edge, death in end/or inv	occurred at the tirestigetion, in my o	me, date and piece, opinion, death occur	and due to the cared at the time, do	ause(s) and ma ate and place,	inner as st and due to	tated. o the cause(s	1)
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	(J. Men (1)	completed cause of death (Item 2			, Baltimo	re, Mary	land 21	1201		
	State State	31. Date filed (Month, Dey, Year)	32 Registrar's Signatu	March	2						

* Registrar



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W	ILLIAM H	1U(GHES III PART I, 27, 28A-F PER 1. Decedent's Name (First, Middle, Las	MEO G761 7-				Health and I		Reg. No.	215	7
	Physicia /Medica Examine	al		iam R. I			IN	4b. City, Town, or BALTIM	Month JULY Location of Death	Day 9 1998 4c. County	Year 1	522 PM
	Funeral Director		Social Security Number 6. Security Number			lest birthday, Yrs.		r If Under 24 Hrs	8. Date of Bir (Month, De	N/A b, Year) 3, 1976		Stete or Foreign
	ath with the Maryland 23a or 28a-f show	ector	Maryland N/A		10c. Cit	y, Town or L Balti	more				1	side City Limits
	a 23a or 2	Funeral Director	10e. Street and Number 3330 Chestnut		Cuaria II	C 12	10f. Zip Code 2121	1	annihi Van ar Na	U.S.		dien
070	ours after deal	þ	11. Maritel Stetus 1 ☼ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Yeer or Detes:		,5. 13.	was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No	Hispanic Origin? (S ben, Mexican, Puer Specify:	o Rican, etc.)	Specify	ck, White, etc.	arears,
0200-91212	within 72 hours after death with the Maryland ene. then "netural", or items 23s or 28s-f show he Medical Examiner must be notified at	Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	+)	(Give	dent's Usuai Occi a kind of work don DO NOT use retir Binder	e during most of wo	rking		usiness/Industry	
Maryland 2	be filed that Hygi d other avent, t	o Be Co	17. Fether's Name (First, Middle, Last) William R	. Hughes,	Jr.		billder	18. Mother's Nar	me (First, Middle,	Maiden Suman		CO.
sattimore, mary	Pages 1 and 2 should nent of Health and Mer int: If item 27 is marke iry or other traumatic		19e. fnforment's Neme/Reletionship (7 Mary Canapp (Mot 20a. Method of Disposition 1∑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	ype, Print) her) Removal from State	20b. P	Place of Disperentery, cre		tnut Aven	urel Route Numb	er, City or Town, imore, 20c. Location -	Marylan City or Town, S	d 21211 State
Baltil	permit. Page Department of important: If any injury or once.		21. Signature of Funeral Service Licen	Seit.	Q	2	2. Name end Add A. Alan 3818 Rol	ress of Fecility Seitz, Jr and Avenu	. Funera	al Home Lmore, M		
)	Physician /Medical Examiner		23a. Part1. Enfer the disease, or comp shock, or heart feilure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each in	TIC I	NTOXICA	TION	ying, such es cardia	c or respiretory a	rrest,	Inter	roximete val Between et and Death
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r.O. 80x	that the death certificate ed by the attending physidetached for use as the	Physician/Me	Part II. Other significant conditions co	d.	ut not resu	ulting in the u	underlying cause (given in Part I.		tobacco use co Yes 2□ No		cause of death?
ecords	8 2 2	Completed by							24a. Was	en eutopsy ormed?	available	ufopsy findings e prior to ion of cause ?
II II II	yslcian: The la s certificate ha director, paga	De Con	25. Was case referred to medical exeminer?						1 🗷	Yes 2□No	128Yes	2 No
Vision of V	Ing Phys Wher this uneral di	ation: 10	XXYes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospitei: 1 Inpatie 28a. Date of Inju (Month, De) UNKNOWN		ER/Outpatie 28b, Time of Injury UNKNOW	of 28c. Inj		dome 5 Resi 28d. Describe UNKNOW	how injury occur		T SCENE
DIVIS	vital or Attand urs after death ral Director: /	Certification:	3 ☐ Suicide 6 🖾 Could not be determined	building, etc	NOWN		reet, factory, office		City or To	UNKNOW	N	te Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only 2 Medical Exam	relcfan: To the best of Iner: On the basis of and manner sta	examinat		ivestigation, In my	opinion, deeth occu		dete and place,	end due to the	
)	with the contract of the contr	-	29b. Signature and title of certifier	(Na	d	ty, M	p 0.	C.M.E		JULY	10, 19	
			30. Name end address of person who c	Radent				et, Baltim	ore, Mar	ryland 2	21201	

State * Registrar

Stephen S. Radentz
31. Date filed (Month, Dey, Year)
32. Registration JUL 141998

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#1 per Phy G761 7/14/98 EW 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month **Physician** Harman 551 /Medical 4a. Facility Nama (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** IA Extended Care enter enter Baltin If Undar 1 Year If Under 24 Hrs. /timore Baltimore, City 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplaca (Stete or Foreign Country) **Funeral** 1X M 2□ F Months Days Yrs. 216-14-1589 Director 75 March 27, 1923 Baltimore, City MD. Usual Residence of Decedant the Marylend 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be nothind at Baltimore 1 ☐ Yas 2 ☑ No Director Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 33 Willow Path Court 234 21236 USA Funeral qeeth 12. Was Decedant Evar in U,S. Armed Forces? 1 ☑ Yas 2 ☑ No If Yes, Give Year or Detas₩W Ⅲ Hems 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, apecify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. filed within 72 hours after 1 Naver Married 2 Married Department of Heelth and Schould be filed within 72 hours aft Department of Heelth and Mentel Hygiens. Important: if item 27 is marked other than "naturel", or in any injury or other traumatic event, the Medical Federal D Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Johns Hopkins School Elementary/Secondary (0-12) College (1-4or 5+) Manager Of Medician 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Be Reuben Lewis Harman Marrie Wilson 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Helen Harman (Wife) 33 Willow Path Court Baltimore Maryland 21236
sposition (Name of Data 20c. Location - City or Town, State 20b. Placa of Disposition (Name of cematery, crematory or other piece) 20a. Mathod of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from Stata Parkwood Cemetary July 10, 1998 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Lassahn Funeral Home, Inc. 21. Signature of Funerel Service Licenses 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heer failure. List only one cause on each line. 7401 Belair Road Baltimore, Maryland 21236-Approximate Intarval Between Onset and Death **Physician** heimer's Disease /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner Sequentially tist conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The lew requires that the death certificate be exec P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 DUnknown signed to Records, ģ is certificate has been si director, page 2 should I Completed 24b. Wera autopsy findinga available prior to 24a. Was an autopay periormed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; s 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Divining Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 Yas 2 No 2 Accident 3 Sulcida 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, atreet, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and mannar as atlated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner atlated. edical 29a. Certifier

31. Date filed State Registrar

29b. Signature and title of certifi-

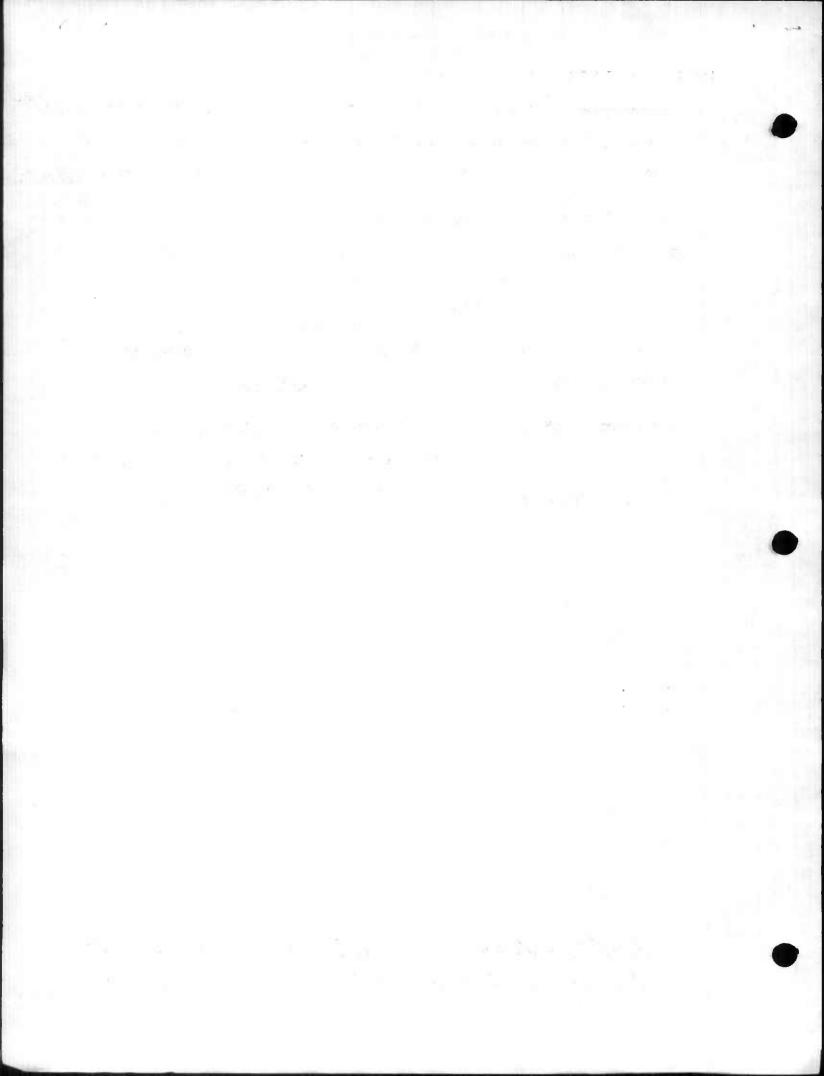
Balto 32. Degistrar's Signature ha Davidson

completed cause of deeth (Item, 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year)

tended Care Center



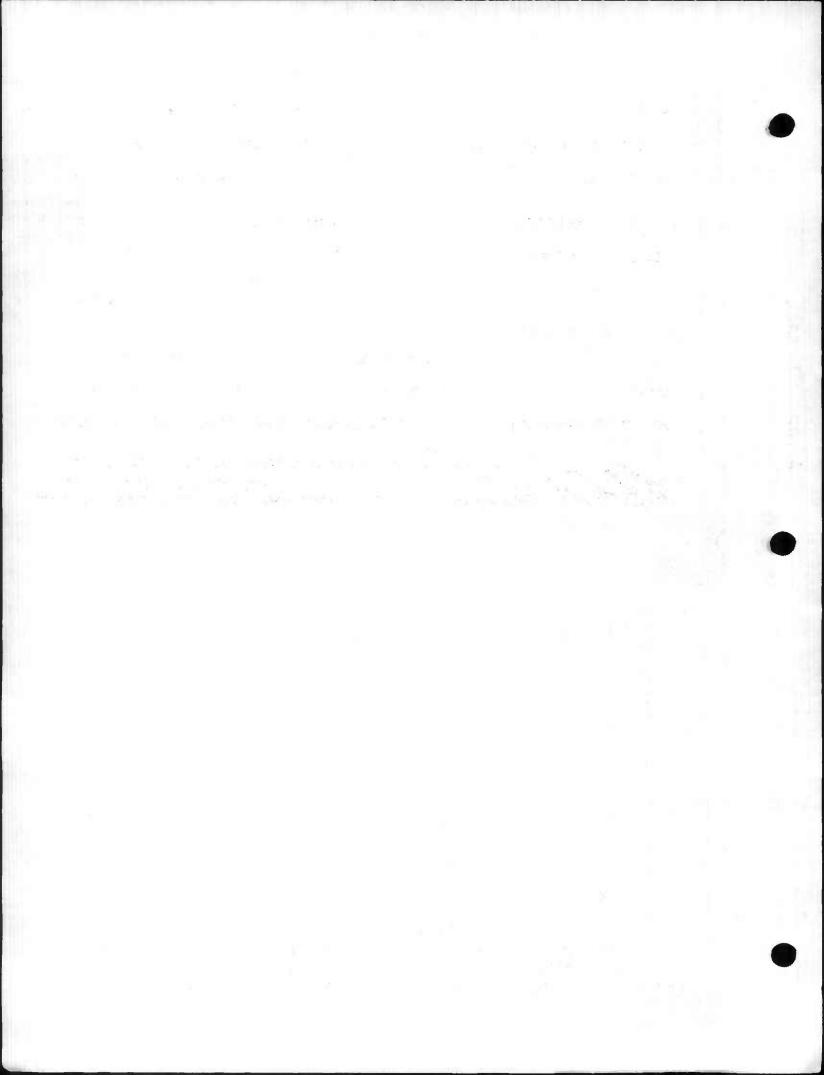
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		4 Donetlop					SVOHL	ER FRIE	INDL	Y SOC	IETY	7/10/	98 DUI	NDALK	, MD
permit. Pa Department important any injury ance.		21. Signature of Far	neral Selvice L	iogótica				22. Name end	Addres	s of Facility	SOT.	LEVIN	SON & BE	ROS.	TNC.
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The law requires that the death certificate be at the has been signed by the attending physicia page 2 should be detached for use as the bur	by Physician/M	CONGES	GIVE	HEA	TR9	FAI	LURE					10	Yes 20 No	3 Pro	bably 4 Unknown
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law lasb	d													of	death?
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	×	29b. Signeture end t	itie of cartifier			ころい	NG	29c.	Licansa	number			29d. Data signe	d (Month,	Day, Year)
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Reg DHMH 16 Ray 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Betty M. Ingram JULY 13 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore

If Under 24 Hrs.
Hours | Min. | 8. Deta of Birth (Month, Day, Year) | Apr 14, 1935 If Undar 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X Months Days 63 Yrs. **Director** 217-30-4463 Usual Residence of Decedent the Manylend r 28a-f ahow 10a. State 10h County 10c. City, Town or Location Directo N/ABaltimore Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? d 2 should be filed within 72 hours after death with ith and Mentel Hygiene.
7 is marked other than "natural", or flems 23a or traumatic event, the Medical Exercitive must be a U.S.A 310 West 30th Street 21211 Funeral 12. Was Decedent Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Naver Marriad 2 Married 1 ☐ Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) NGRAM, BETTY Elementary/Secondary (0-12) College (1-4or 5+) Switchboard Operator Notre Dame of MD 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edna Wilson Edward Cotter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Heelth enc Important: if item 27 is m any injury or other traum page. 310 West 30th Street, Baltimore, Maryland 21211 Edward H. Ingram (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gdns 7/16/98 Timonium, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licansee A. Alan Seitz, Jr. Funeral Home 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

Appropriate the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

Appropriate the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

Appropriate the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

Physician /Medical **Examiner**

Division of Vital Records, P.O. Box 68760,

is certificate has director, page 2 s

funeral

n 24 hou... the Funeral Dis-

To the Hosp within 24 hou To the Fune completely fi

Be

To

Certification:

Medical

or Attending Physician: efter death. Director: After this certifica

Physician

Immediate Cause (Final disease or condition resulting in death) Examiner requires that the deeth certificate be executed

physician and strength the buriel-trans Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical þ Completed

Approximate Interval Between Onset and Death SEPTIC PNEUMONIA Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death?

METASTATIC COLON CANCER

Hospital:

1 Yes 2 No 3 Probably 4 1 Onknown

24a. Was an autopsy

Reg. No.

Day

1998

14. Race - American Indian,

Black, Whita, etc.

Specify: White

College of

N/A

2. Date of Death

3. Tima of Death

9:50 A.M

9. Birthplace (State or Foreign

10d. Inside City Limits YYes 2 No

Country) Maryland

24b. Ware autopsy findings available prior to completion of causa of death?

21211

1 Yes 2 No 26. Piace of Death (Check only one)

1□Yes 2NNo

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Decedent's Nama (First Middle Last)

5 Pending Investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work?

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

> 28d. Describe how injury occurred 1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Angelodha Leven, M.D.

29c. Licansa number AT 2438946

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print)

ANURADHA ARUN, N.D. UNION MENORIAL HOSPITAL, BALTINORE, M.D. 21218

Registrar

31. Date filed (Month, Day, Year)

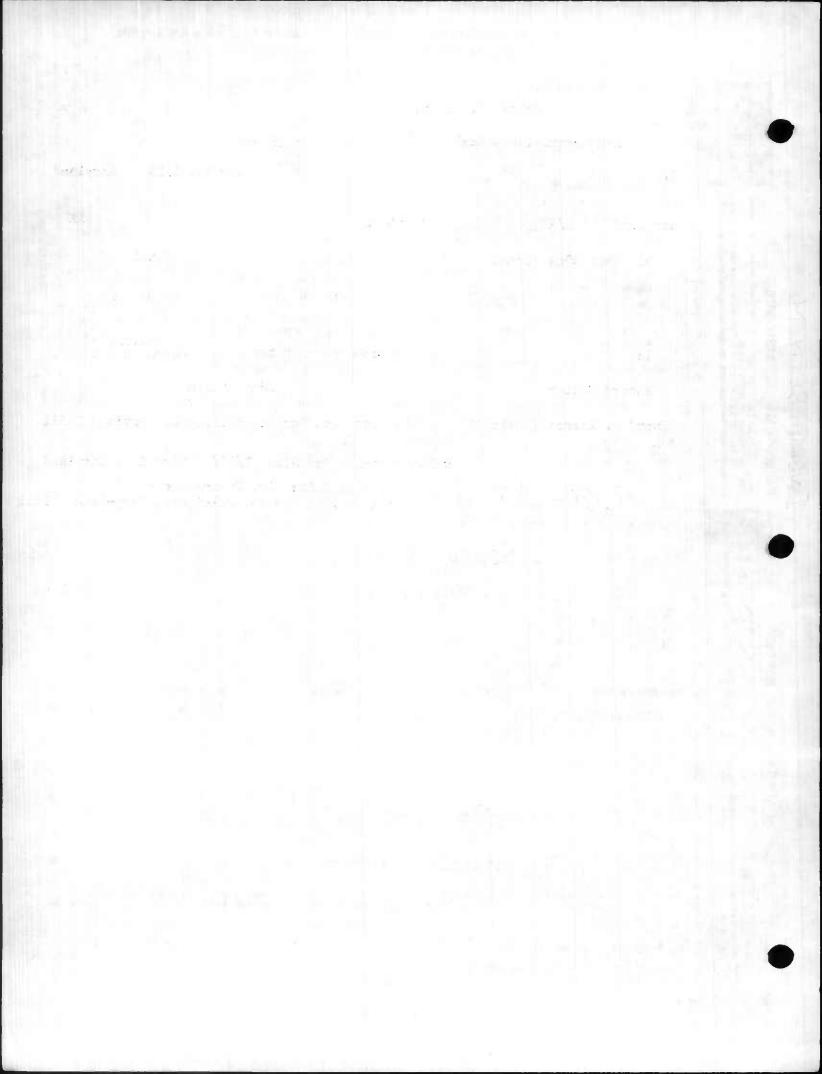
JUL 141998

32. Registrar's Signature Julia Davidson-Randale

DHMH 16 Rev 6/95

JULY - 13-1998

29d. Date signed (Month, Day, Year)

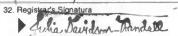


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death .JULY **Physician** 09 1998 08:16AM CLINTON JONES /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE or If Under 24 Hrs. CITY 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Montha Hours Min **★**□ M 2□ F Yrs March 23, 1967 212-88-0810 31 Maryland Director Usual Residence of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Md. Baltimore Essex 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 511 Riverside Road 21221 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after C Department of Heelin and Mental Hydinea. Important: If Item 27 Ia marked other than "natural", or the any injury or other traumatic event, the Marical Examine 1X Never Married 2 Married Baltimore, Maryland 21215-0020 White 1 Yes 2X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working lifa. DO NOT usa ratired) (Specify only highest grade completed) Elemantary/Sacondary (0-12) College (1-4or 5+) Cabinet MAker Canntella 12th 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Jones Vernie Smith 2 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Jones / father 511 Riverside Road Baltimore Md. 21221 20b. Place of Disposition (Name of cametery, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Buriel 2 Cremetion 3 DRemovel from State SacredHeartofJesus 7/11/98 Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service Licensea Connelly Funeral Home of Essex altons that ceused the death. Do not an er the mode of dying, such as cardiac or raspiratory arrest, as cause on each line. 23a. Part1. Enter the disease, or composhock, or haart failura. List only Approximata Interval Batwean Onset and Daath **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical THORACIC AORTIC PSEUDOANEURYSM WEEKS Examiner Due to (or as a consequence of): Examiner attending physicien end for use as the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) detached for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the Records, P.O. signed by t 3 Probably 4 Unknown 1 Yes 2 No by 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peed has 1 Tyes 2 No 1 ☐ Yes 2 ☑ No After this certificete Division of Vital 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Attending 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation Mospital or Attending 24 hours after death
 Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide TV Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

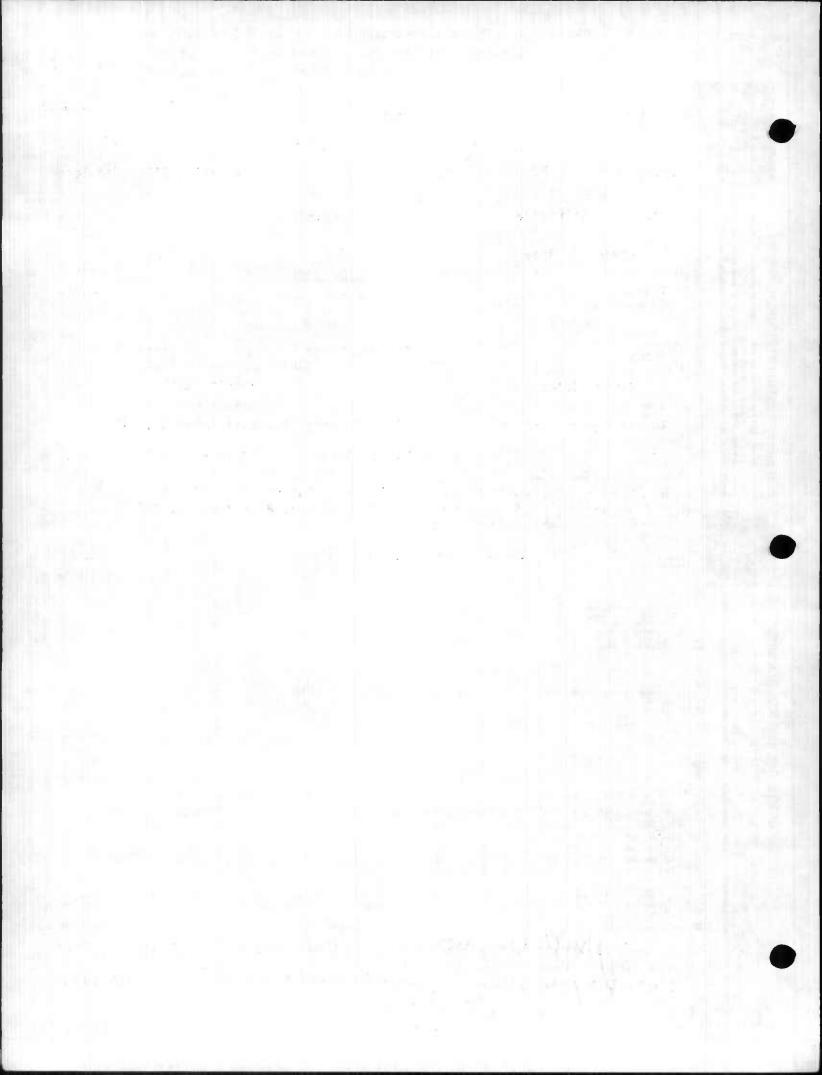
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifian Medical (Check only one) To the 7 within 2 To the 6 complet 29d. Date signed (Month, Day, Year) 29b. Signature and tale 29c. License number MO DES.000 of death (Item 23a) (Type, Print) JOHNS HOPKINS HOSPUM, BANNINGE MO 21257

State Registrar

31. Date filed (Month, Day, Year)



DINER 110

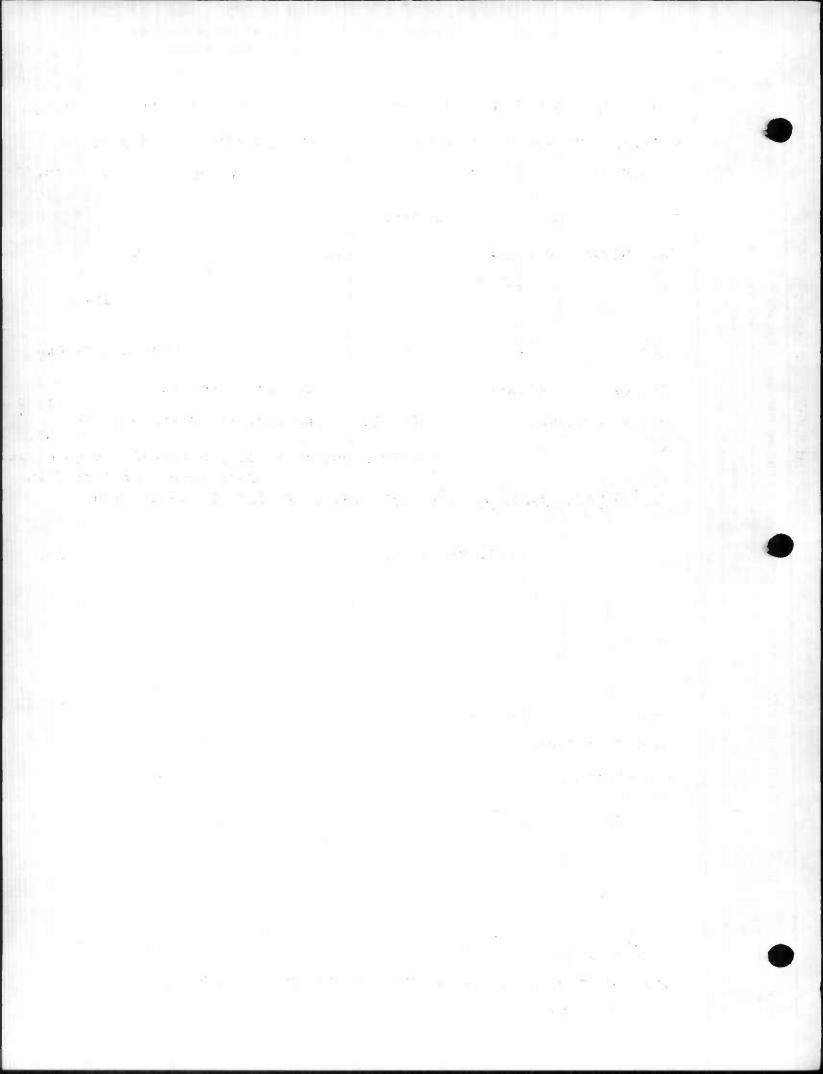


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vision	or Attending
Divi	
	e Hospital

	1. Decedent's Nam	e (First, Middle, L	ast)							2. Date of Dea	ath Day	Year	3. Time	a of Death
Physician /Medical	Micha	el Do	nald d	Johnson	n, S	r.				July !			12:	05pm
Examiner	4a Facility Nama (If not institution, g	iva street end nu	mber)				4b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
	VAMHCS,			DIVIS				FORT		VARD	BALTI			
Funeral	5. Social Security N		Sex 1 DM 2 DF	7. Age (In yrs.	lest birtho	Months	Days		Min.	8. Data of Birt (Month, De		Count	7/	te or Foreign
Director	215-40- Usual Residence o		X	53		s.				12-28	3-44	ватт	1mc	re,MD
show of all	10a. State	10b. County		10c. Cit	y, Town o	or Location						10	d. Inside	a City Limits
28a-1 sh notified	Md	N.	A	Ва	alti	more							1 % Y	′as 2 □ No
or 284	10e. Street and Nu	mber				10f. Zip	Coda			T	10g. Citizen of V	/hat Count	ry?	
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ifter death with the Mer r teams 23e or 28e-f si since must be northed Funeral Director	11. Marital Status		12. Was Dec	edant Evar in U	S.	13. Was Dece	dent of I	Hispanic Or	igln? (Sp	ecify Yes or No- Rican, atc.)		- Americe k, White, a		1,
or its arrive arrive y		ied 2 Married	12/CXYes If Yes, G	2 No		1 ☐ Yes					Specify			
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and has me	19a. Informant's N	ame/Relationship	(Type, Print)								er, City or Town,	Steta, Zip	Code)	21212
and 3	Sylvia	Johns	on			0 Yor		oad A	Apt.		Baltimo			
of H of H or oth	20a. Method of Dis	position Cremation 3	☐Removal from	State	emetery,	isposition (Na cremetory or o	ther ple		i	Date	20c. Location -			
ment tent:	4 Donation	5 ☐ Other (Spec	city)		Garr						7-15-98			
permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If frem 27 is marked other than "natural", or its any injury or other traumatic avent, the Medical Example once. To Be Completed by Furnish	21. Signature of Fu	neral Service Lic	ensae	1 ()	22. Name a	nd Addre	ess of Facili	ty B	Baltimo	ore, Ma	ryla	nd	21202
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Physician /Medical	Immediate Cause	(Final											- Jew. (8)	
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certificate rector, pag	25. Wes cese refer	_						26. Plac	e of Deat	h (Check only o				- 1-1-1
Z 00 D	examiner? 1 ☐ Yes 2 ☐	No	Hospital:	Inpatient 2	ER/Outp	atient 3 D	DA Ot	her:			dence 6 Oth	er (Specify)	
After this funeral di	27. Menner of Deat	h 5 Pending	28a. Date (Mor	of Injury oth, Dey Year)	28b. Tin Inju	ne of	28c. Inju Wo	iry at ork?		28d. Describe	now Injury occur	ed		
tal or Attending P rs efter death. al Director: After t led in by the funers Certification:	2 Accident	investigati	on		İ	М]Yes 2□	No					
ker d frect n by rtiffe	3 Sulcide 4 Homicide	6 Could not determine	d Zee. Plac	e of Injury - At hi ling, etc. (Specil		n, street, factor	y, office			28f. Location (Street end Numb vn, State)	er or Rura	Routa f	vumber,
Urs e C	20.00	Les and the same			Carrier to		Elicania.		1		Western and	STIES IN		
To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer Medical Certification:	29a. Certifier (Check only one)	2 Medical Ex	miner: On the b								ceuse(s) end me date and place,			se(s)
or the or the omple	29b. Signature and	title of certifier	ano mai	iner states.	17	29	c. Licen	se number			29d. Data signe	d (Month, I	Dey, Yes	ir)
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11/	30. Name and eddr	ress of person who	completed cau	se of death (Item	n 23a) (Ti	vpe, Print)	1	171	J 0		1			
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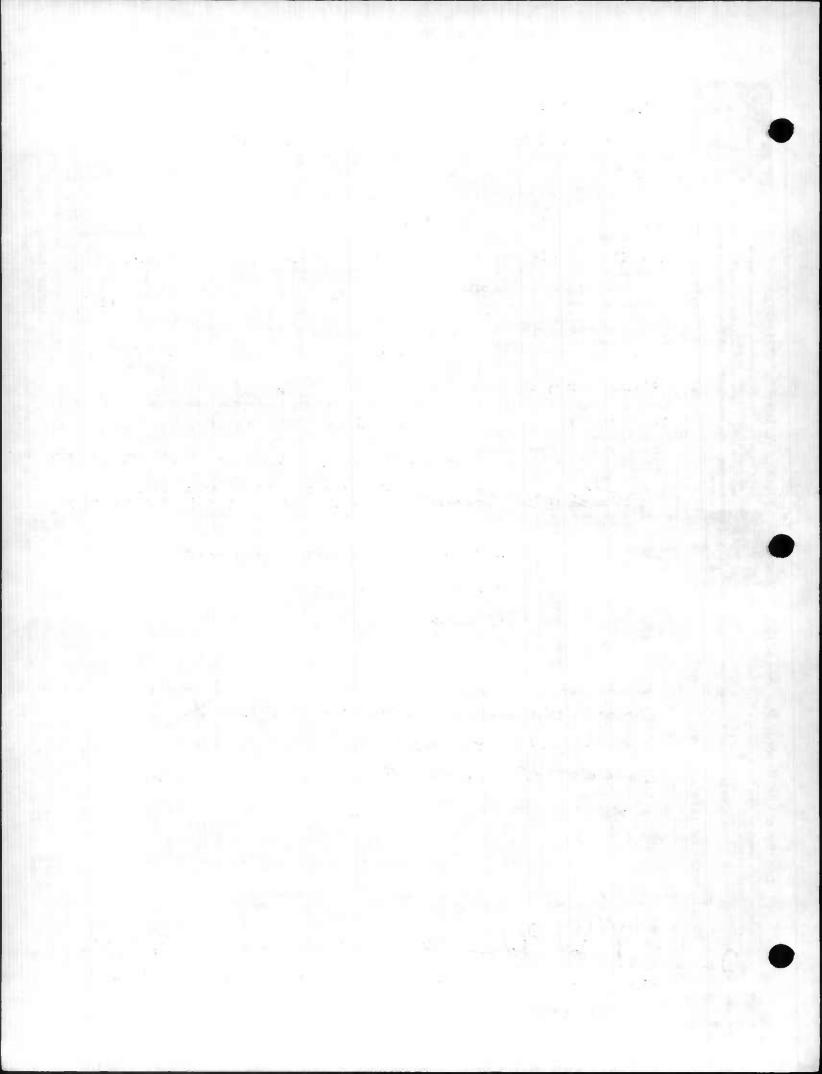
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Reg. No.



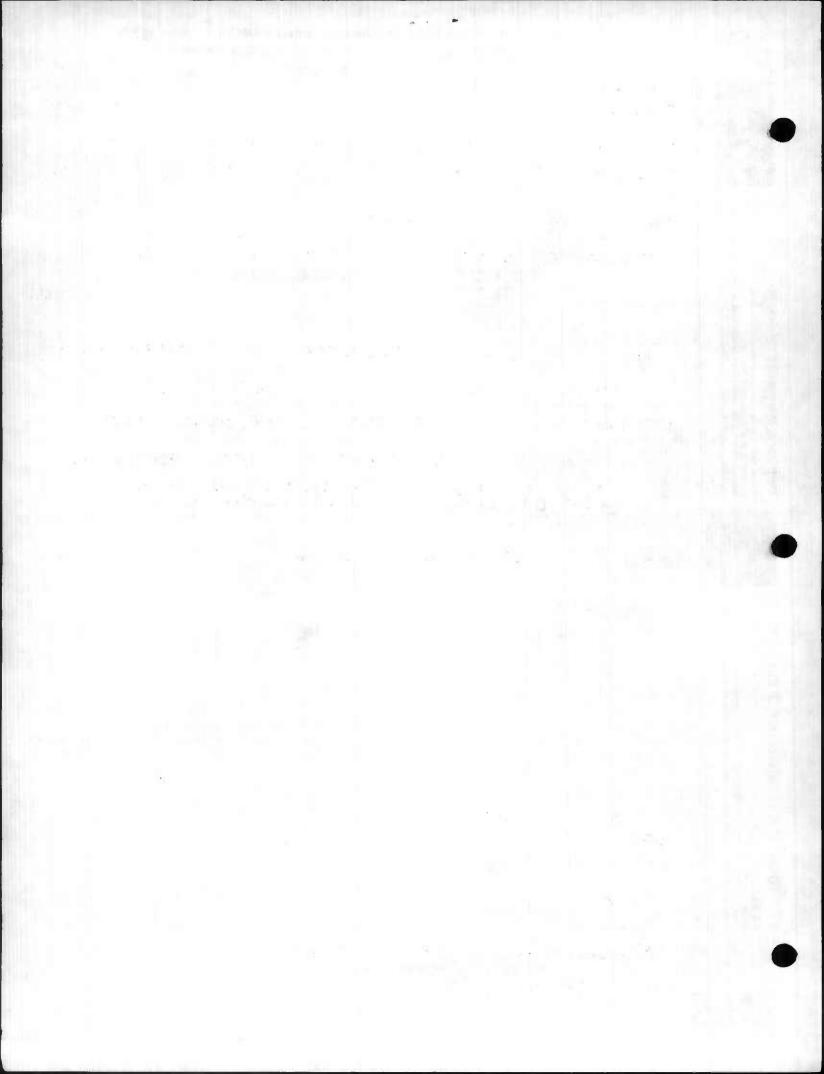
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Phys /Me Exai Fune Direct Germanus KNOERLEIN permit. Pages 1 and 2 should be fitted within 72 hours after doubt with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

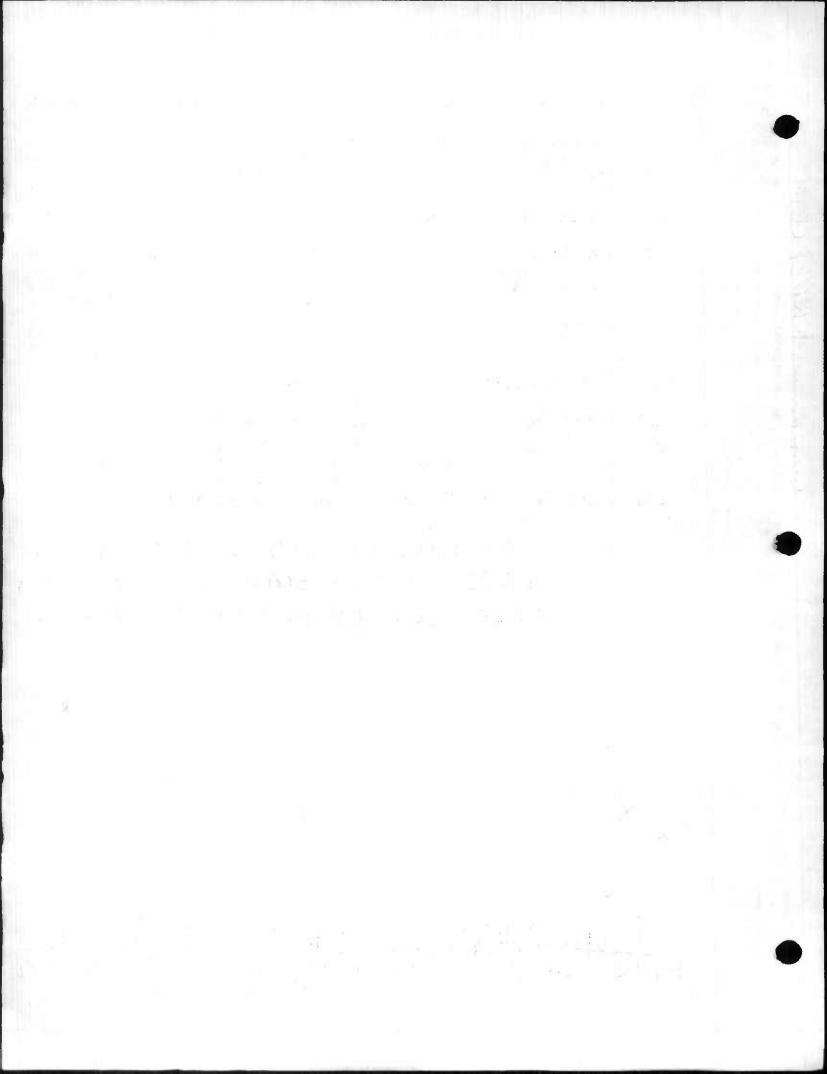
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OFP	ROSTAT	IL	16 wentes
nce of):	_		
orlying ceuse given in Per	rt I. 23b. Did t	tobacco use cont	tribute to the cause of death?
	10	Yes 2□ No	3 Probably 4 Unknown
			24b. Were autopsy tindings evailable prior to
			of death?
	1 🗆 Y	res 2 No	1 ☐ Yes 2 ☐ No
26. Pla	ace of Death (Check only o	nne)	
	Nursing Home 5 ☐ Resid	dence 8 Other	r (Specify)
28c. Injury at Work?	28d. Describe h	now injury occurre	ed
M 1 Yes 2	□No		
, factory, office			er or Rurel Route Number,
curred at the time, date a	and place, and due to the death occurred at the time.	cause(s) and man	nner as stated. nd due to the ceuse(s)
T			
29C. License numbe	160	290 Dete signed	(Month, Dey, Year)
DIT	100	JULTI	R) 1110
		111.1111	QAITIMOG
A RITC	HIE HIGH	FAWH	/ IDALITYIVE
3	26. Pla 26. DOA Other: Work? 1 Yes 2 factory, office	tyling ceuse given in Pert I. 23b. Did it is a series of Death (Check only of Death (Check o	tyling ceuse given in Pert I. 23b. Did tobacco use com 1 Yes 2 No 24a. Was en eutopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Cher: 4 Nursing Home 5 Residence 8 Othe 28c. Injury at Work? 1 Yes 2 No 28d. Doscribe how injury occurred work? 28d. Location (Street and Number City or Town, State) 29c. License number. 29d. Dete signed

State Registrar 31. Date filed (Month, Pey, Year)

Figure Fundall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🖯 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month KISNER 17.45 RICKIE 1998 08 JULY 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BACTIMORE CITY TOPKINS HOSPITAL THE JOHNS + 8. Dete of Birth (Month, Day, Year) June 15, 1948 If Under 1 Year | if Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1XM 2□ F Months 215 42 7355 West Virginia Usual Rasidanca of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 7989 Willow Oak Lane 21122 U.S. 14. Raca - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. 11. Merital Stetus 1% Yes 2 No Viet Yeer or Detes: 1 Never Married 25% Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Nam 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Flementary/Secondary (0-12) Coltege (1-4or 5+) Mechanic Md. Trans. Authority 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Betty B. Wolfe Junior W. Kisner 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 7989 Willow Oak Lane Phyllis Kisner / wife Pasadena, Maryland 21122 20b. Place of Disposition (Name of cematery, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State 7/13/98 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) State Veteran Cem. 22. Name end Address of Facility 21. Signature of Funeral Service License Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 raminouski Part 1. Enter the disease, or call shock, or heart failure. Use on infications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, one cause on each line. Approximete Interval Between Onset and Daath CIRCULATORY FAILURE Immediate Cause (Final 1 HOUR disease or condition resulting in daeth) Dua to (or as a consequence of): LIVER FAILURE FULMINANT Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): 2DAYS BLEEDING GASTROINTESTINAL Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas 20 No 1 Tyes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medicai Examiner

Injury or Depertment of Important: If any Injury or

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Peges 1 and 2 should be filed within 72 hours effer on ant of Health and Mentel Hygiene. ont: If item 27 is marked other than "natural", or item

altimore, Maryland 21215-0020

the Merylen

death

/Medical

Directo

Funeral

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Completed

physicien and s the buriel-tren 80 950 signed to

Examiner Physician/Medical þ Completed page 2 Be 10 Certification:

certificete be exec Box 68760, P.O. Division of Vital Records, Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certific

State Registrar

To the Hosp within 24 hor To the Fune completely fi

edical

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Sulcide

29a Certifier

31. Date fited (Month, Day, Yaar)
JUL 14 1998

CYXIL RUWENDE

29b. Signature and title of certifier

5 Pending

6 Could not be detarmined

uwende

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrer's Signature Kia Cavidoon

RESIDENT PHYSICIAN

28b. Time of

4/4

N/A

28a. Placa of Injury - At home, farm, street, factory, offica building, etc. (Spacify)

28c. Injury at Work?

1 Yas

W/4

28a. Date of tnjury (Month, Day Year)

NA

28d. Describe how Injury occurred NA

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

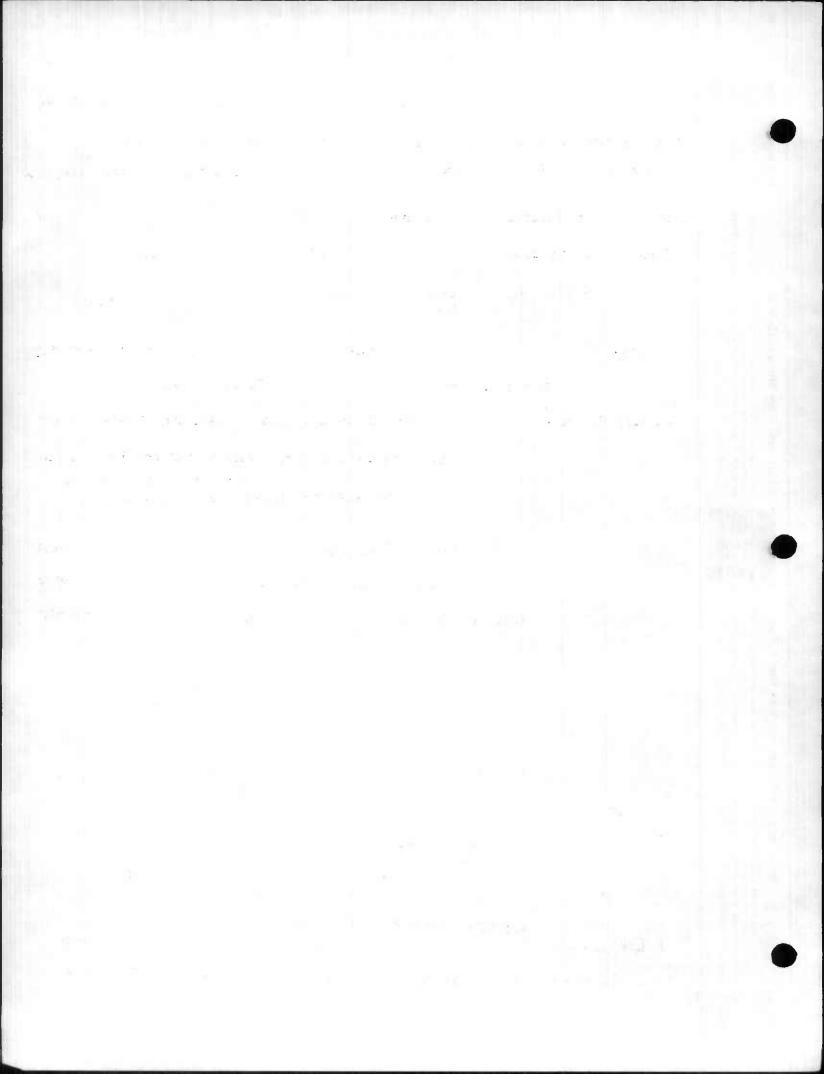
12 Certifying Physician: To the best of my knowladga, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) RES - 000

1998 JULY 08

1830 EAST MONUMENT STREET, BALTIMORE,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** JULY 10, LEON KLEIN 1998 4:30 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street and number) **Examiner** 8415 BELLONA LANE #507 TOWSON BALTIMORE If Undar 1 Yaer If Undar 24 Hrs. Birthplece (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys Hours Min 1 XM 2 ☐ F Yrs **Director** 86 MARCH 25,1912 PA 181-10-2414 Usual Rasidence of Decedant with the Meryland 10e. Steta 10c. City, Town or Location 10d. Insida City Limits 10b. County ral", or items 23a or 28a-f ahow Examiner must be notified at 1 ☐ Yes 2 No TOWSON BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 8415 BELLONA LANE #507 21204 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any hijury or other traumatic avant, if a Marical Examination once. Funeral 14. Race - American Indian, Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 11. Marital Stetus Black, Whita, atc. 1 Nevar Merried XX Married 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Yas ZXNo Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Dacadant's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Cotlega (1-4or 5+) Elementary/Secondary (0-12) MERCHANT RETAIL 18. Mothar's Neme (First, Middla, Maidan Sumama) 17. Fether's Nama (First, Middla, Last) Be P FLORENCE FRIEDMAN WILLIAM 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 8415 BELLONA LANE #507 TOWSON, MD 21204 SYLVIA KLEIN (WIFE) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - Cify or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 7/12/98 REISTERSTOWN, MD BALTIMORE HEBREW 21. Signature of Funerel Sarvice Licensae 22. Nama end Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart fallure. List only one cause on each line. Approximeta Intarvat Batwaen Onset end Death **Physician** Immediate Causa (Final diseesa or condition resulting in daath) /Medical 2 menls Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediata causa. Entar Underlying Causa (Disaase or Injury that initiated avants The law requires that the death certificate be ex Division of Vital Records, P.O. Box 68760. attending physician lor use es the buna 2 Dug to for as a consequence of rasulting in daath) Last ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to Completed 24e. Was an autopsy performed? peeu completion of cause of death? has e 2 1 Yas 2 ONG 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Dresidenca 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 8 Other (Specify) this 28a. Data of fnjury (Month, Day Year) funeral 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of Certification: 28c. fnjury at Work? After 1 or Attanding 1 DNetural 5 Panding 1 Tas 2 No n 24 hours efter death.

Funeral Director: A pletely lilled in by the fu Invastigation efter death. 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicide 1 Certifying Physician: To tha best of my knowledge, deeth occurred at tha tima, data and place, end dua to the ceuse(s) end mannar as stated. 29e. Certifle Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, deta and place, and due to the causa(s) and manner stated. (Check only one) within 2 29c. Licansa number 29d, Deta signed (Month, Day, Year) 29b. Signatura and titla of certifian

200

State Registrar

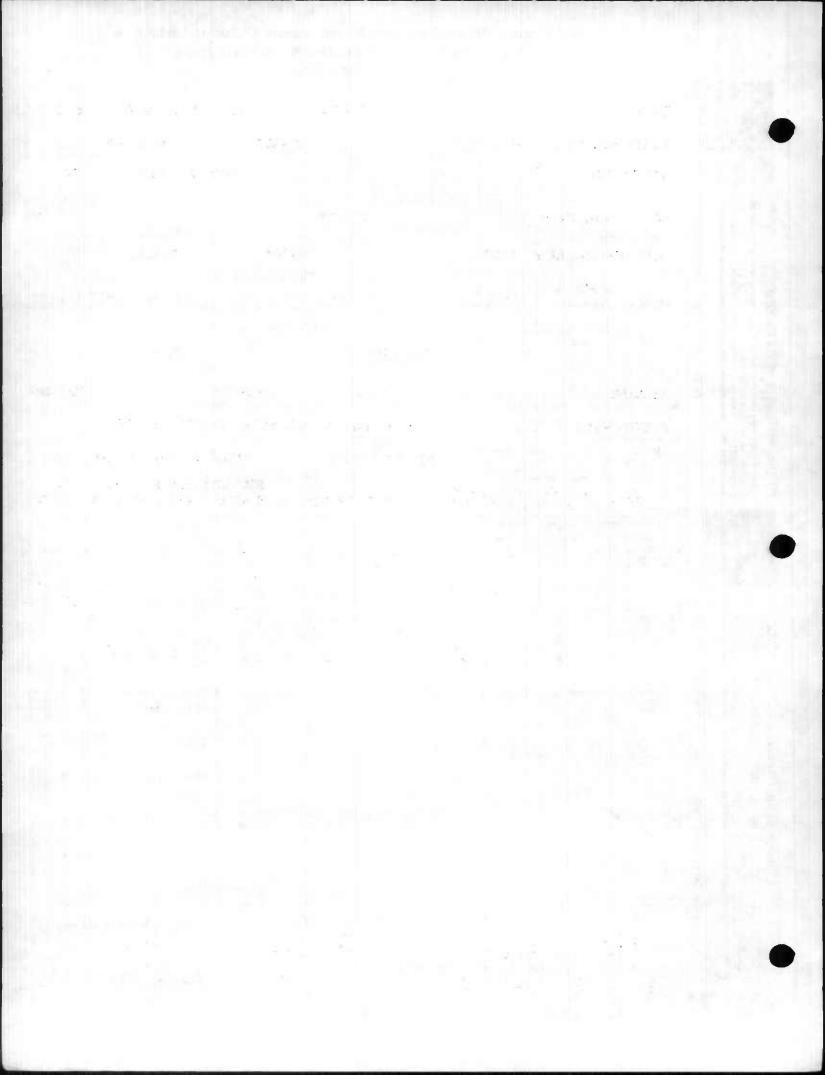
IaN 31. Data filed (Month, Day, Yaar)

30. Nema and address of person who complated causa of death (Itam 23a) (Type, Print)

hen

32. Registrar's Signeture

wia Davidson



Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Yaar Month Edward G. Kramer July 1998 6, 11:45AM 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) 7422 Shipley Lane Baltimore Kingsville If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociei Sacurity Number Birthplace (State or Foraign Country) 7. Aga (In yrs. last birthday) 1X M 2 F Months Yrs. 215-14-5946 Oct. 3,1920 Baltimore, Md. Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 ☐ Yas 2 🕽 No Maryland Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7422 Shipley Lane 21087 U.S.A. 12. Was Dacedent Ever In U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: W.W.Ⅱ 14. Race · American Indien, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 11. Marital Status Bleck, White, etc. 1 ☐ Never Merried 2 X Merried 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Bethlehem Steel 12 yrs. Supervisor 4 yrs. 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Edward George Kramer, Sr. Mary Amelia Magness 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. Informent's Name/Retetionship (Type, Print) Mrs. Mary E. Kramer (Wife) 7422 Shipley Lane Kingsville, Md. 21087 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Steta 1 ☐ Burial 2 ACremetion 3 ☐ Ramovel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 7/7/98 | Baltimore, Maryland 22. Name end Address of Fecility 21. Signeture of Funeral Sarvice Licensel E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Maryland 21087 assak 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finet 3 week disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or tripiny that initiated events rasulting in deeth) Lest Due to (or es e consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given of Pert I. 23b. Did tobacco use contribute to the cause of death? 24e. Wes en eutopsy performed? completion of cause of deeth? 1□ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? 1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Menner of Deeth 28c. Injury et Work? 28e. Dete of tnjury (Month, Day Year) 28b. Time of 28d. Describe how tnjury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

Be

Peges 1 end 2 should be filled within 72 hours aftar death with the Marylend nent of Health and Mental Hygiena.

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

7 is marked other than "natural", or frams 23a or 28a-f shot fraumatic event, the Woolcal Exposition must be motified at

of Health a ltam 27 lt

= 5 permit. Pege Department of Important: If any injury or

> Examiner physician a Physician/Medical as signed by the a þ Completed Be

that the death certificate be executed aw ils certificate has t director, page 2 s Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifical ethy filled in by the funeral director; 24 hours To the Hospi within 24 hou To the Funer completely fil

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Certification:

edical

State Registrar 31. Dete tiled (Month, Day, Year)

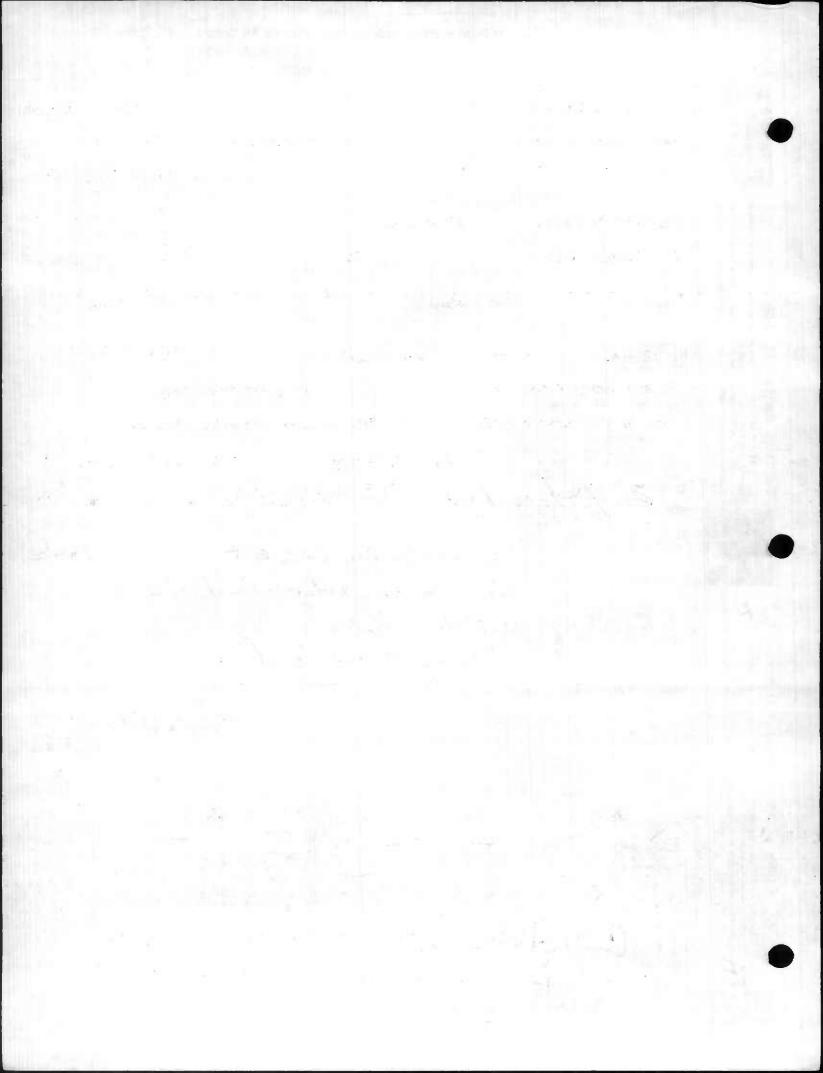
Neturet 5 Pending Investigation injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a Certifier

Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner es steted.

| Medical Examiner: On the basis of axaminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29b. Signature and title of cutifier 29d. Dete signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of deeth (Item 23e), (Type, Print) 664 Box MD P. O.

32. Registrer's Signeture The Handon- pandage



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 2 PEr PHY Film G761 7-17-98 rja Item 24 Per PHY Film G761 7-14-98 rja Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death June 22 **Physician** 1998 JOHN ALAN LOGAN 10:55 PM /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8712 Jenifer Road Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) 5. Social Sacurity Numbar 7. Aga (In yrs. iast birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Months 1⊠M 2□ F 65 Yrs. Director 219-28-9742 October 26,1932 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location pernit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic avent, the Medical Examine must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10a. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8712 Jenifer Road 21234 U.S.A. 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 N Yes 2 No It Yes, Give Yaar or Datas: 1953--55 1 Nevar Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: White 2 3 Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grads completed) 16b. Kind of Business/Induatry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Repairman Household appliances 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maldan Sumama) Be John McIntyre Logan 2 Myrtle Lighthiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Carle Elaine Logan/wife 8712 Jenifer Road, Baltimore, MD 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Policial Service Licenses 22. Name and Address of Facility Wade Director Renald S. State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

23h Part Enter the disassa, br complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** Immediate Cause (Final disaase or condition resulting in death) /Medicai FAILURE LIVER 2 WEEKS Examiner Due to (or as a consequence of): Examiner cirrois Chronic many physician end the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or Injury Due to (or as a consequence of): markenage Box 68760 many Chronic Physician/Medical that initiated evants resulting in daath) Last Due to (or as a consequence of): 88 attending 950 for signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown STAGE CARDIONOPATHY Š 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed has 1□ Yes & No 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case reterred to medicei examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mannar ot Death 28c. Injury at Work? To the Hospital or Attanding P. within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred 1 Denatural 5 Pending invastigation 2 Accident 1 Yes 2 No 6 ☐ Could not be detarmined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, offica building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of cartifiar 29c. Licanse number 29d. Data aigned (Month, Day, Year) m 0 39 757 25 98

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BALTIMORE ND 21239

State Registrar LUTFI

31. Date filed (Month, Day, Year)

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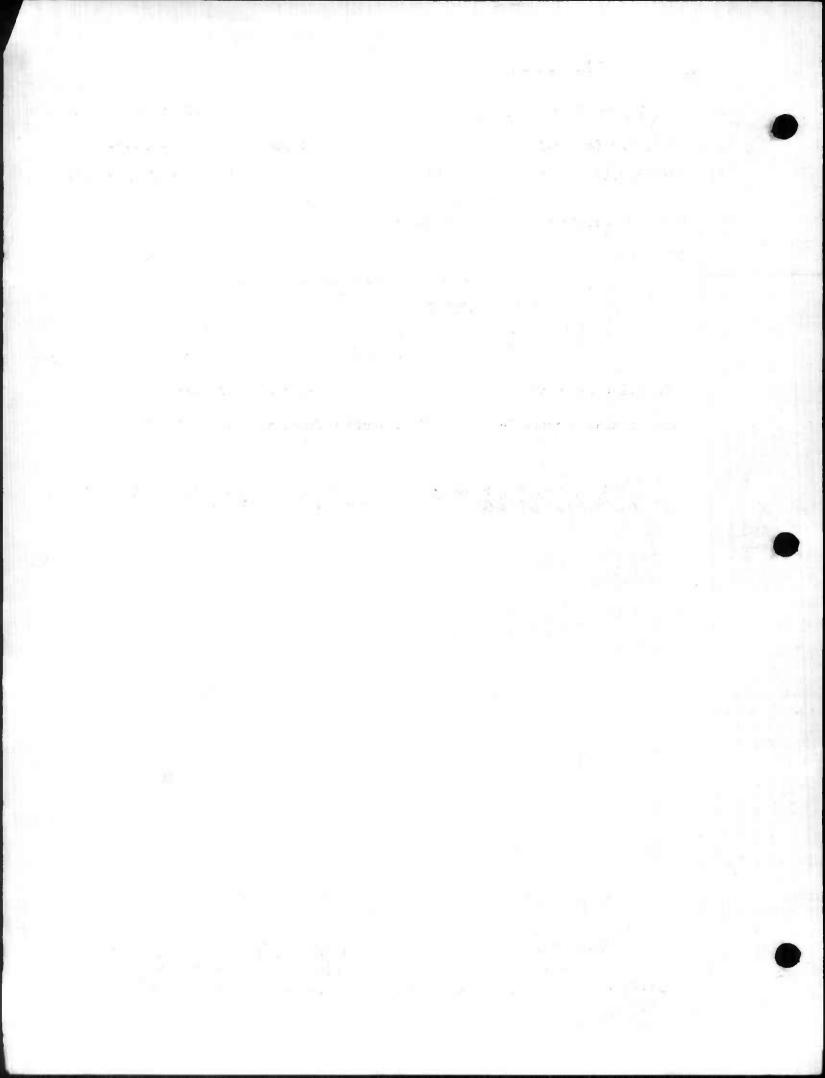
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev **Physician** 11, 1998 3:50 PM July Joseph Thomas Landers, Jr. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not Institution, give street end number) Examiner 5304 Carter Ave Baltimore If Under 1 Year Birthpleca (State or Foreign Country) 7. Age (In yrs. lest birthdey) 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) **Funeral** 100 M 2□ F Months. Deys Yrs. Director 10-31-1933 214-30-3967 Maryland death with the Maryland 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location x 28a-f show 1 Yes 2□ No Director Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or traumstic event, the Wedical Examiner must be a 21214 U.S.A. 5304 Carter Ave. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 Yes 2 N No 14. Reca - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status Bleck, White, etc. 2 should be filled within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iter 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementery/Secondery (0-12) College (1-4or 5+) Mechanic Sewing Machines 12 Years 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth jury or other traumatic every Mary M. Luby Joseph T. Landers, Sr. 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Janet Landers (Wife) 5304 Carter Ave. Baltimore, Maryland Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removet from State 4 □ Donetion 5 □ Other (Specify) Department of Important: If any Injury or once. 7-15-98 Baltimore, Maryland Parkwood Cemetery 22. Name end Address of Fecility 21. Signature of Funger Service License Leonard J. Ruck, Inc. 21214 Baltimore, Maryland 5305 Harford Road refine riplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, y one cause on each line. Approximete tntervel Between Onset end Deeth **Physician** non-smallcell lung cancer /Medical Immediate Ceuse (Finel month diseese or condition resulting in death) Examiner Examiner The law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): physician ar Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy Completed s certificata has t director, page 2 s 1 ☐ Yes 🔊 No 1 □ Yes 2 □ No or Attending Physician: efter deeth. Be 25. Wes case referred to medicat 28. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 1 SNeturel 5 Pending 1 Yes 2 No Investigation 2 Accident Director: / 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o 29e. Certifier 🅰 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifie

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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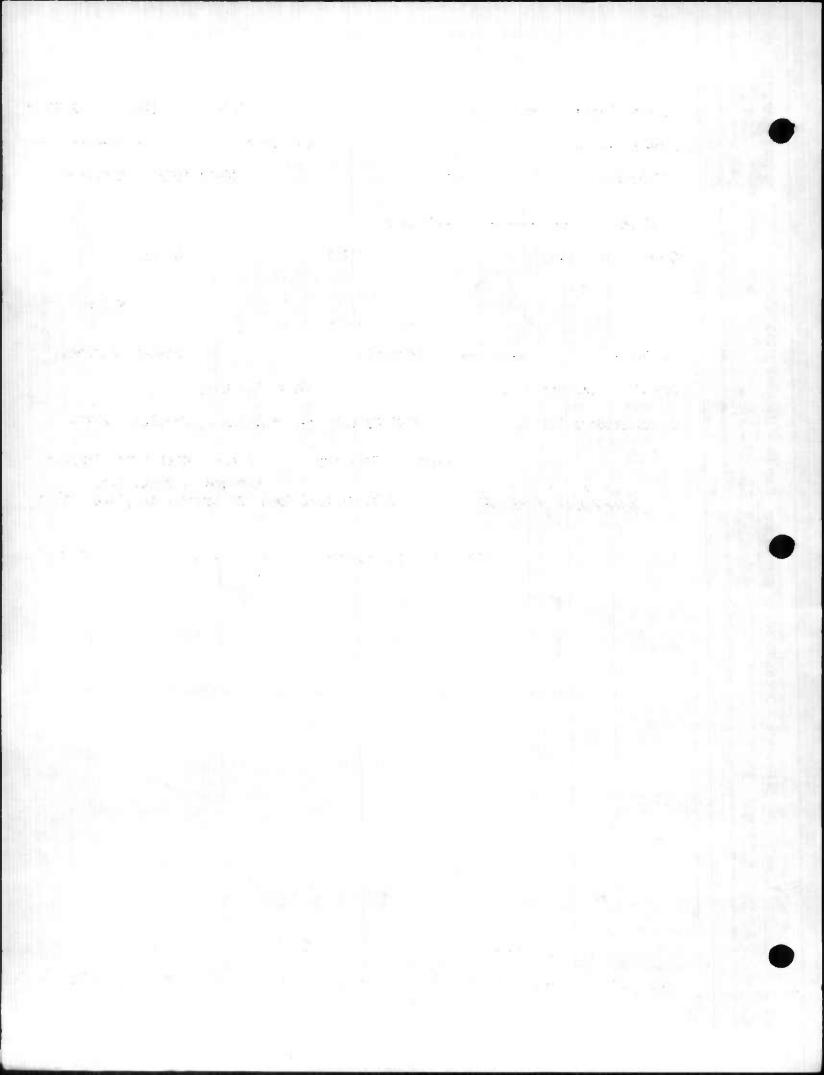
31. Date filed (Month, Day: Year)

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32. Registrer's Dignature

Loth

relia Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month LUBTTZ JULY 7, 1998 3:15 AM MORRIS 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) 3406 MILFORD MILL ROAD BALTIMORE BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) XXM 2 F Months Days Yrs. MD 79 FEB.9, 1919 214-01-9162 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No BALTIMORE MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21244 U.S.A. 3406 MILFORD MILL ROAD 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. 1 X Yes 2 □ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ▼No Specify: WHITE WWII 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) TRANSPORTATION 11 CHAUFFEUR 18 Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) LUBITZ SHER LENA PHILIP 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) (WIFE) 3406 MILFORD MILL ROAD BALTIMORE, MD NAOMI LUBITZ 20b. Place of Disposition (Name of cametery, cremetory or other place) Dete 20c. Location - City or Town, Steta 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) PROGRESSIVE RUDOMER VEREIN 7/9/98 ROSEDALE, MD 21. Signetine of Funeral Service Licensee 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD euro er the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Acute Myceardiof Infarctions Immediate Ceuse (Finel diseese or condition resulting in death) Carcinoma of Metastatic Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evellable prior to completion of ceuse of death? 24a. Wes an autopsy performed? 2 1 No 1 Yes 2 N 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8 ☐ Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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permit. Pegas 1 and 2 should be filed within 7. Department of Haelth and Mentel Hyglena. Important: If Item 27 is marked other than "ne any injury or other treumatic event, the Wedge page.

altimore, Maryland 21215-0020

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P.O. Box 68760. Division of Vital Records, Aftar this funaral daeth. after daeth Director: filled in by 5 24 hours a Hospital complately

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25. Wes cese referred to medical exeminer? 1 Yes 2 UNG 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

1 Denifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.

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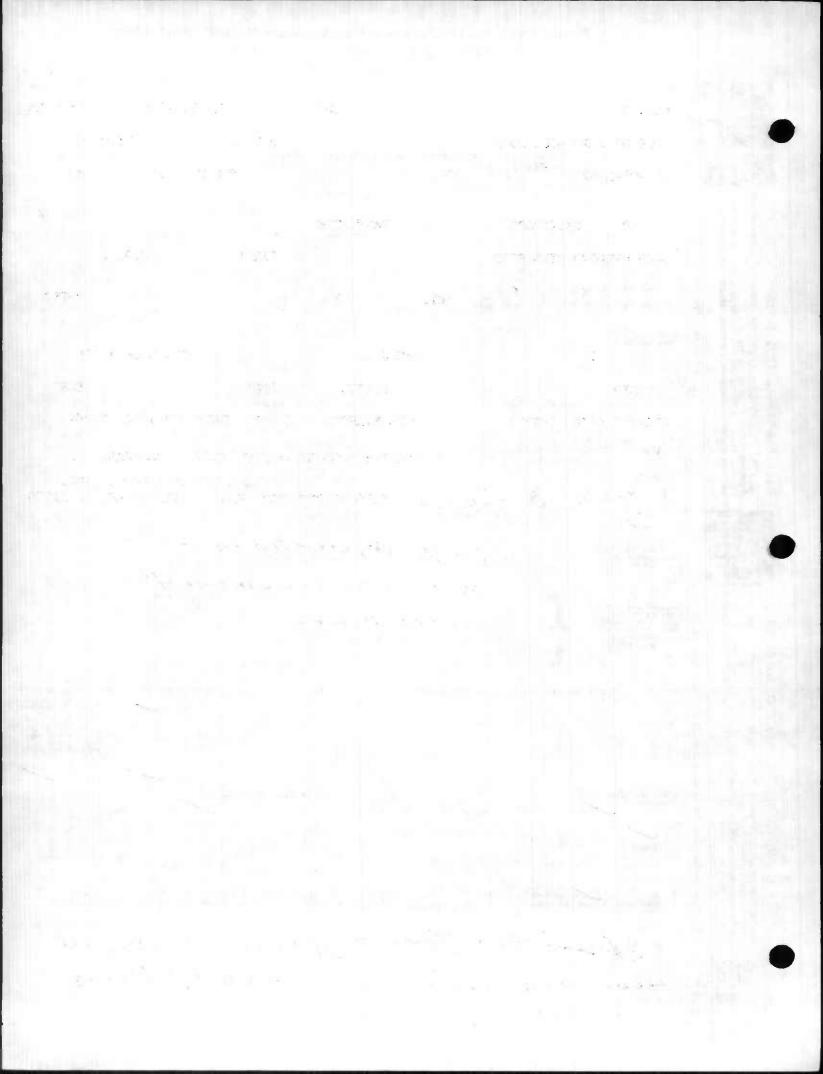
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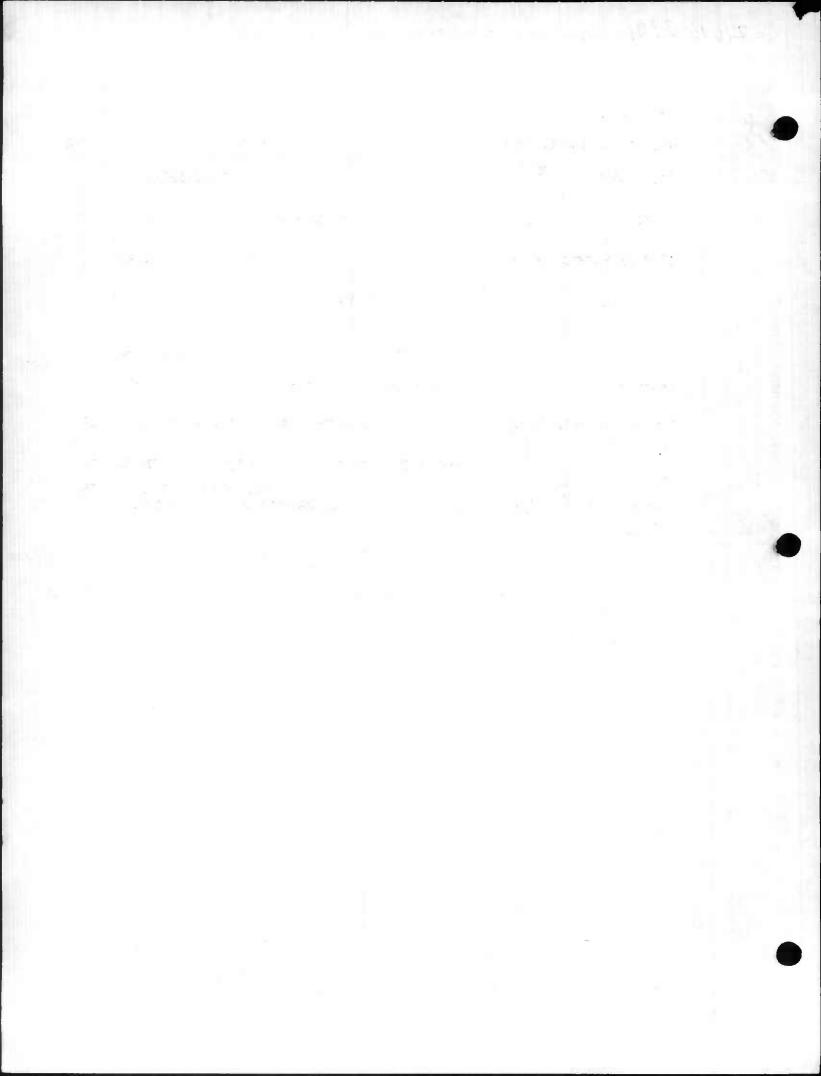
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JUL 14 1998 32. Registrar's Signature

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altimore,	t. Page rtment o rtant: If		20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW 20c. Location - City or Town, State 7/9/98 BALTIMORE, MD											
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🖂 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Yaai Ahmoud JULY 1200 1998 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death MEH BAH If Undar 24 Hrs. Altimore WA NION Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 6. Sax If Undar 1 Yaar 8. Data of Birth (Month, Day, 104M 20 F Months Days Hours Min 369-82-6812 Yrs. gypt Usual Rasidance of Decadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Egypt 10e. treel and Number 1 ☐ Yas 2 No ARRO - 94PT 10f. Zip Coda 10g. Citizan of What Country? Ea Road MAAdi NO 12. Was Dacedant Evar in U.S. Armed Forces? 1 Yes. 225No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race American Indian, Bleck, White, atc. 11. Marital Status 1 Navar Married 25 Married 1□ Yas 2 No Specify: Eq Specify ptiAu 3 Widowad 4 Divorcad 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Adminstation YES 12+H GERDE GOU T 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) FARAhi MAhmoud Sultan LOTAYET 19a. Informent's Nama/Ralationship (Type, Print) 21093 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Clenefield ARIM SAShac IR Cutherulle 20c. Location - City or Town, Stata 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) Data 19 Burial 2 Cramation 3 Ramoval from Stata MemoRIAL 7-13-98 KANDALISTOWN TARK 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvica Licansea 22. Nama and Addrass of Facility Wm. CMARCh FUNERAL Home WEST INC Wm. C B 23a. Part 1. Enter the disaasa, or complications that caused the deeth. Do not antar the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. BAITO Approximate interval Batween Onset and Death Immadiata Causa (Final COAGULOPATHY disaasa or condition rasulting in daath) & DISSEMINATED INTRAVASCULAR HOURS Dua to (or as a consequence of): b. HEMMORHAGE 16 HOURS Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that Initiated evants rasulting In death) Last Due to (or as a consequance of): NCTIONING, INFLAMED, PELVIC KIDNEY 2 Dua to (or as a consequence of): CNON-FUNCTIONING RENAL CALCULI 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings evelleble prior to complation of causa of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yas 2 No 26. Placa of Deeth (Check only ona) Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) Hospital: 1 Impatiant 2 ER/Outpatient 3 DOA 28b. Time of 28d. Dascribe how injury occurred

P.O. Box 68760, signed by t Division of Vital Records, certificate has

Examiner Physician/Medical à Completed Be P Certification:

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Completed

7 is marked other than "natural", or itsms 23s or 28s-f shov traumatic event, it a Madical Examinar maint be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Heelth end Mentel Hygiene. Important: If Item 27 Is merked other than "natural", or item any injury or other traumatic event.

Physician /Medicai

Examiner

Baltimore, Maryland 21215-0020

the Maryland

death

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifics filled in by the funeral

State Registrar

edicai

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, 2) DIVERTICULOSIST ANEMIA 25. Was casa rafarred to medical exeminer?
1 Yes 2 No 27. Menner of Daath 26e. Deta of Injury (Month, Day Year) 28c. fnjury at Work? 5 Panding invastigation Injury 1 ☐ Yas 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Sulcida 6 Could not be determined 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 4 I Homicida 1 Cartifying Physician: To tha best of my knowledge, deeth occurred at the time, dete end plece, end dua to tha cause(s) and mannar es stated.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, daath occurred at the time, dete end plece, and due to the causa(s) and mannar stated. 29a. Certifier

> 29c. Licansa numbar SULGICAL AT

29d. Date signed (Month, Day, Year)

MD INTERN 30. Nama and address of person w ompleted causa of daath (Item 23e) (Type, Print)

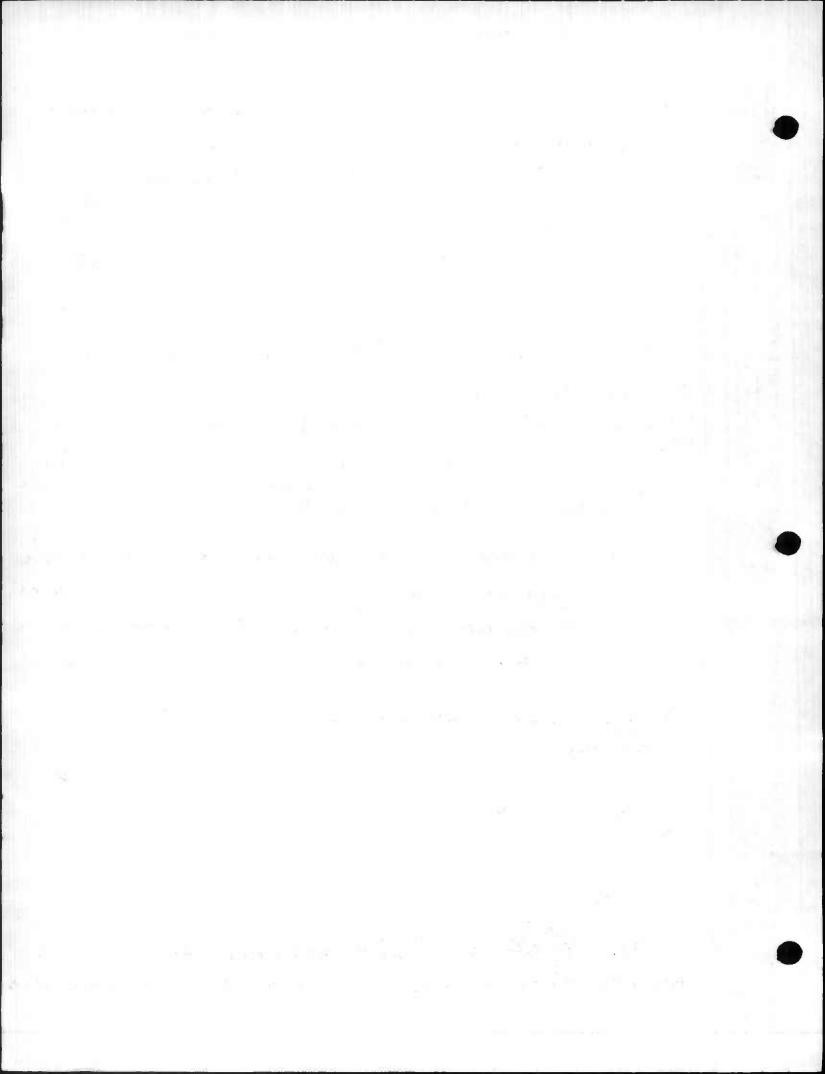
12 2438946 UNION MEMORIAL HOSPITAL, BALTIMORE, MD

31. Date filed (Month, Day, Year) JUL 1 4 1998

29b. Signatura and title of certifier

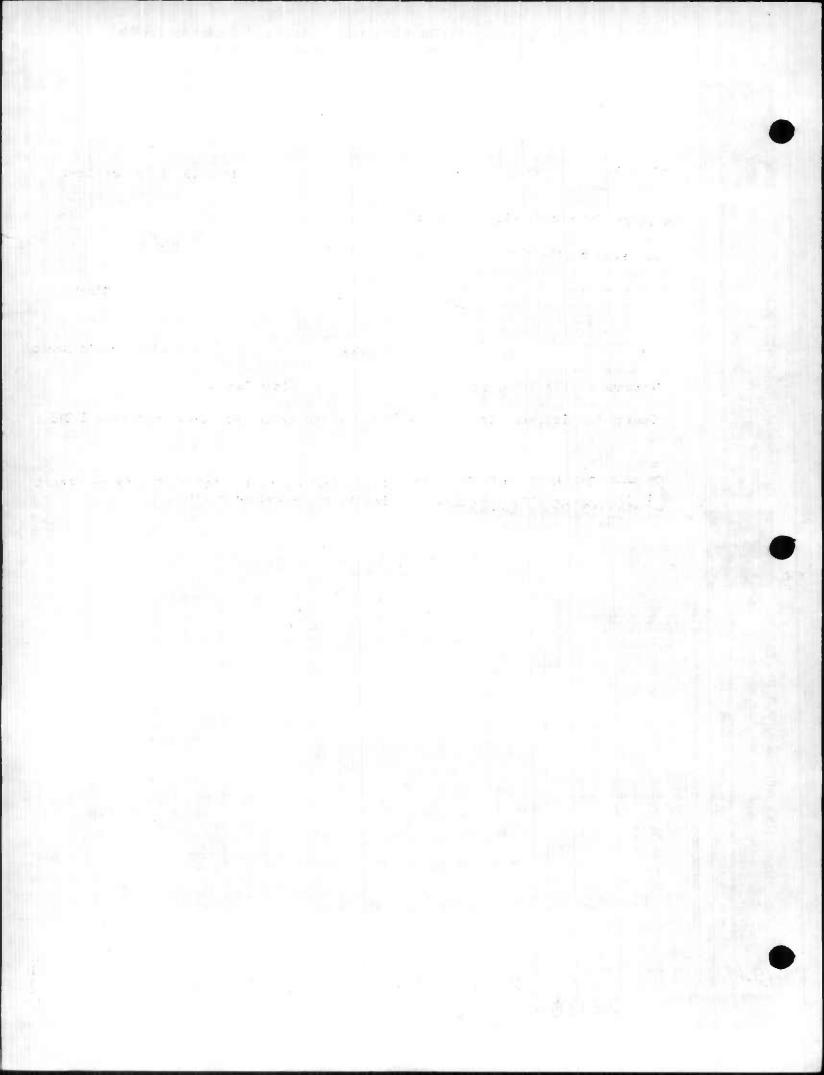
MICHAEL

HARRIS 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Marylan	Certifica				eg. No.	21:	024				
Physician /Medical	20000	" Mitchell				2. Date of Dee Month	Day	Year	Time of Death				
Examiner	4a Facility Name (If not institution, give	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. City											
Funeral Director	213 10 2240	7. Age (In yrs. 83	Yrs. If Und Months		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day Jan. 1.	Year) 3, 1915	9. Birthplace Country) Maryla	(State or Foreign and				
feryland show	Usual Residence of Decedent 10e. State 10b. County Maryland Baltimo		y, Town or Location						Inside City Limits				
offer death with the Meinter death with the Meinter 23a or 28a-1 since Transcription of Finneral Director	10e. Street and Number 1190 West Northe		10f. Z	ip Code 1210			0g. Citizen of V	/hat Country?					
urs of lift, o	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U Armed Forces? 1 IXYes 2 □ No If Yes, Give Yeer or Detes: WWII			nic Origin? (Spe exican, Puerto pecify:	ecify Yes or No- Rican, etc.)		e - American f k, White, etc. Blac					
within then then	15. Decedent's Ed (Specify only highest grad Elementary/Secondery (0-12)	ucation de completed) College (1-4or 5+)	16e. Decedent's Us (Give kind of w life. DO NOT Teach	rork done durin use retired)	g most of worki	ing	16b. Kind of Bu		School				
Be file	17. Father's Name (First, Middle, Last) Clarence M. Mitchell, Sr. Elsie Davis												
and 2 show alth and N 27 is man	19a. Informant's Name/Relationship (7 George D. Mitch		19b. Mailing Addre 4321 Gro										
Pages 1 e nent of He int: If item	20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify	Removal from State	Place of Disposition (No cometery, crematory or	ame of other place)		Date	20c. Location -	City or Town,	State				
permit. Pag Department Important: i any injury o	21. Singular of Fund Ronal Conse. Wade, Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, show, or heart failure. List only one cause on each line. 22. Name and Address of Fecility Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, interval Between the cause on each line.												
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	e. Hemor.	rhagie or es e consequence o	Shoc	[<				erval Between iset and Death				
eath certificate be executed ettending physician end for use as the buriel-transit clary. Medical Examiner	Cause (Disease or Injury that initieted events resulting In death) Last	C	Renal	Failus	e								
y the d													
The law requires that are hes been signed by page 2 should be determined by Pt.						24a. Was a	an autopsy med?	availal	autopsy findings ble prior to etion of cause th?				
Physician: The law require this certificate has been sirel director, page 2 should it. To Be Completed				28	Place of Deatl	1 🗆 Y		1 □ Y	es 2 No				
Physician: r this certific and director,	1 ☐ Yes 2 ☒ No	28a. Date of Injury	ER/Outpatient 3□ I	Other	■ Nursing Ho	me 5 Resid	lence 6 Oth						
tal or Attending Pins after death. In Director: After tied in by the funeraction:	Netural 5 Pending	(Month, Day Year) 28e. Placa of Injury - At huilding, etc. (Specif	tnjury M ome, farm, street, factory)	1 🗆 Yes	2 🗆 No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Medical Certific	29a. Certifier (Check only one) Certifying Phy	vaician: To the best of my kno iner: On the basis of examina	wiedge, death occurre	d at the time, o	late and place, n, death occurr	and due to the d	cause(s) and ma date and piece,	inner as state and due to the	d. e cause(s)				
vithin 2 To the comple	29b. Signeture and title of certifier	and manner stated.	2	9c. License nu	mber		29d. Dete signe	d (Month, De)	r, Year)				
->-	I field	K- rs		AS 29	1023211	-K 9348	July	10 10	79				
2+1	30. Name and address of person who of Line (King	, 2401 W	Belue	der	1	Juen	10-6						
State Registrar	31. Dete filed (Month, Pay, Year)	32. Registrar's Signs	ature Dudge						WLE				



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 98 **Physician** Robert Maroney 10:50 am /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Bout more If Under 24 Hrs. 8. Dete of Birth Min. Month, Dey ital 9. Birthplace (Stete or Foreign Quantry) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1₽M 2□ F Months Deys Yrs. Director Pages 1 and 2 should be filled within 72 hours efter death with the Maryland Health and Mental Hygiena. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28e-f show traumatic event, it a Madical Examinat must be nodified at 1 PYes 2 □ No N Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Rece - American Indien, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U.S. Armed Forces? Armed Forces? 1 ☐ Yes 2 ☐ No Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0020 If Yes, Give Year or Detes: Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ondary.(0-12) Coilege (1:4or 5+) ATORBI 18 Mother's Name (First, Middle, Me. 17. Fether's Name (First, Middle, Last) n Sumama) Be 2 Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number City or Town Stete, Zip Code) If them 27 I 20b. Plac ation - City or 1 Burial 2 Peremation oval from State 5 Other (Specify) Physician /Medical disease or condition resulting in death) Examiner physician and the burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be send Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Standing pl signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown duabel by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy Completed page 2 s 1 ☐ Yes 2 ☑ No 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medical exeminer? Be 28. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No Certification: To 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated.

29c. Ligense number

2401

32. Registrar's Signeture Random

10432

West Belvedere Avenue, Baltymore Idays and

29d. Date signed (Month, Dey, Year)

State Registrar

edical

29a. Certifier

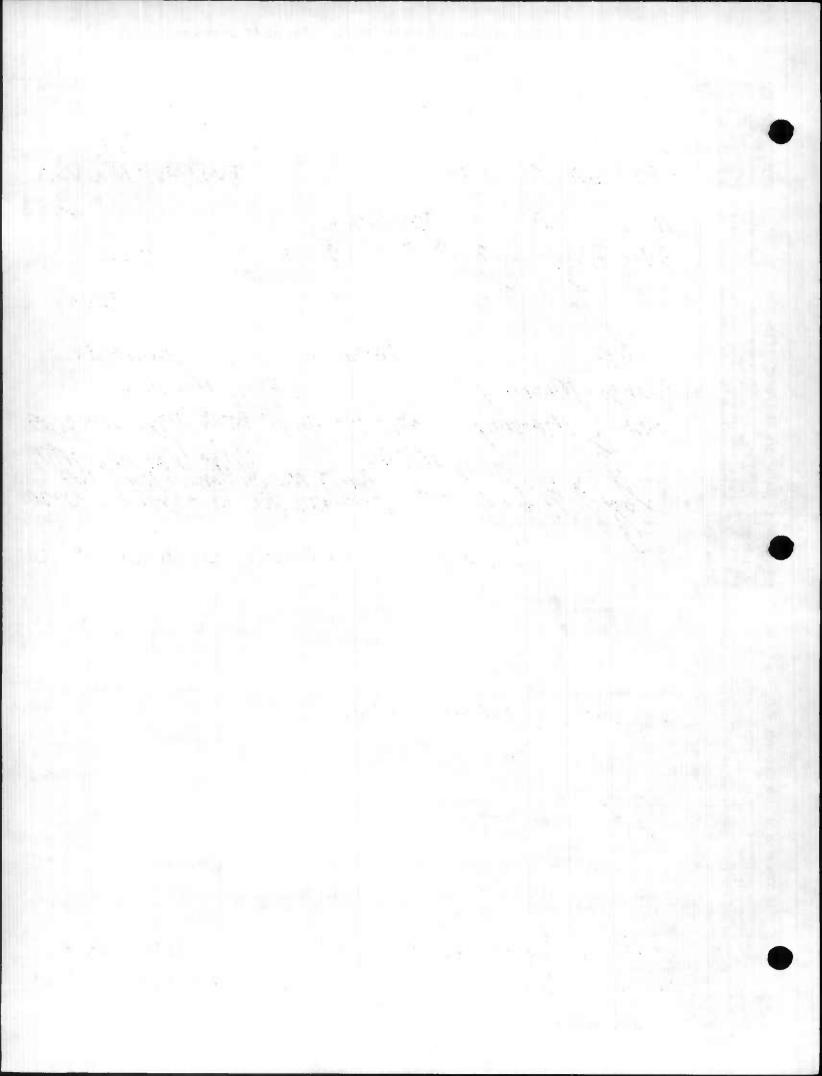
29b. Signeture end title of certifier

31. Dete filed (Month, Day, Year)

141998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Hospital



State Registrar 31. Dete filed (Month, Dey, Year)

32. Registrer's Sign

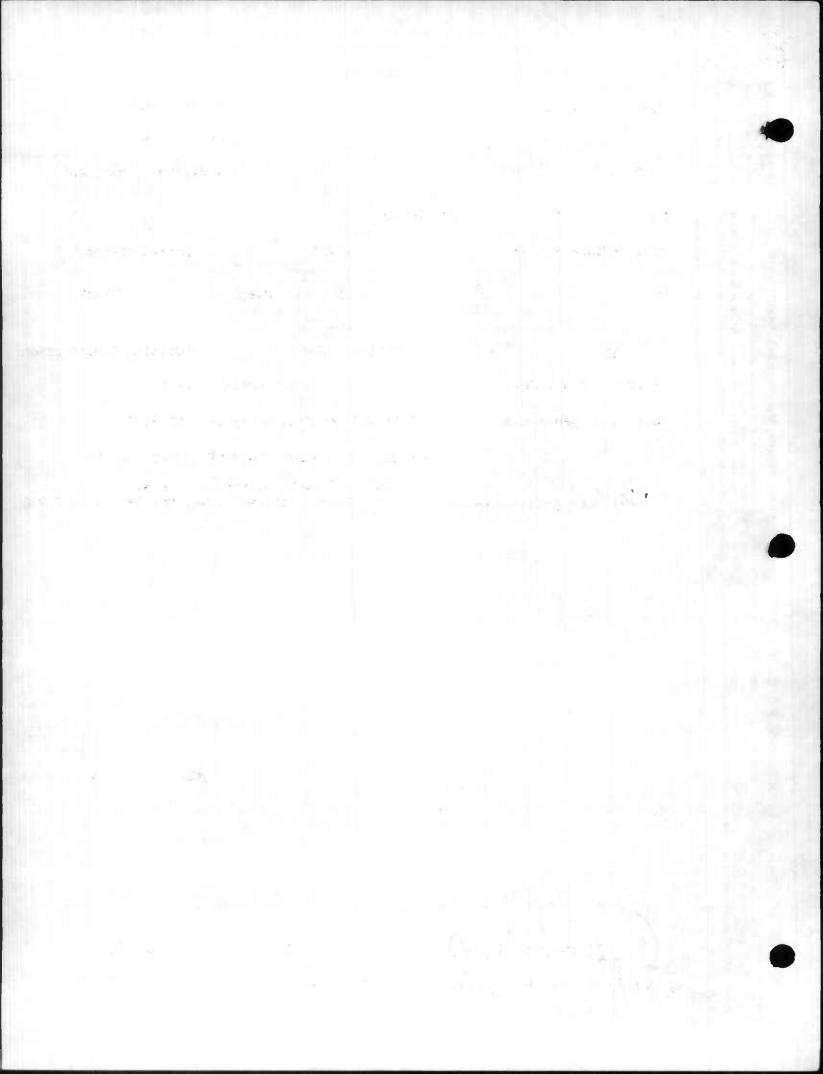
and eddrass of person who complated ceuse of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201
22. Registrer's Signeture

The Lavidson Randelle

O.C.M.E.

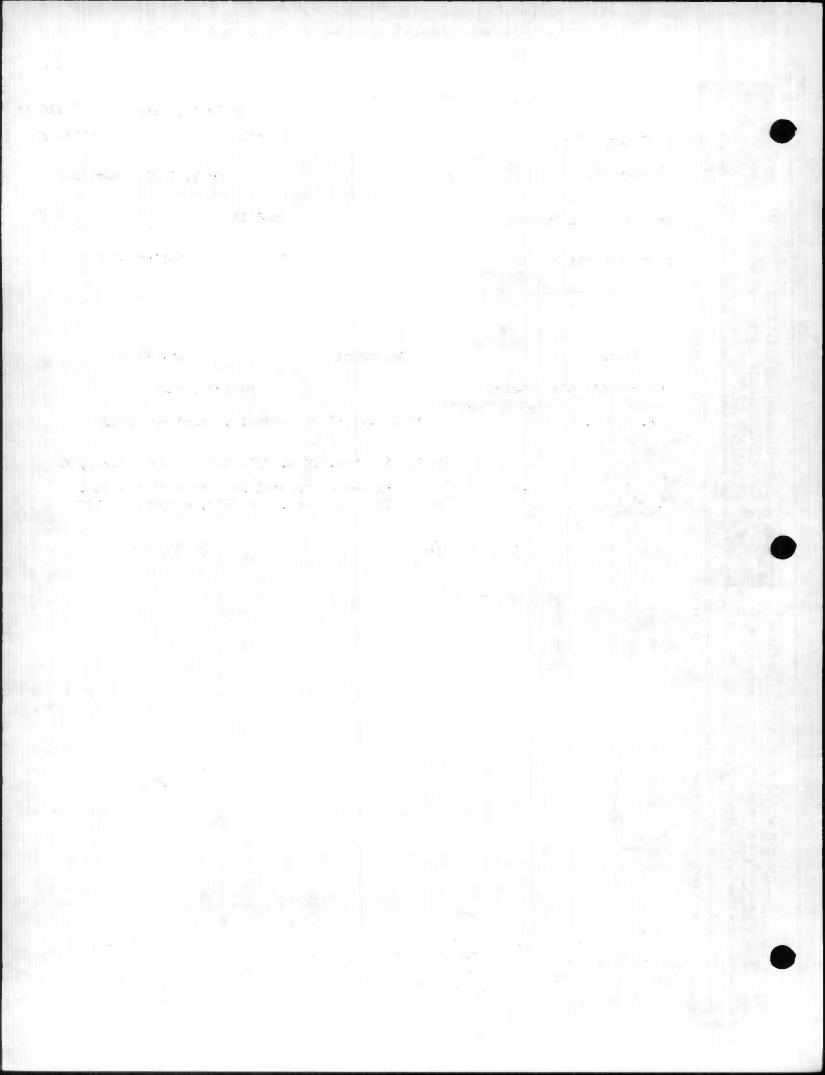
JULY 12, 1998



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State of Maryland / Department of Health and Mental Hygiene 98 21527

			,,,,,	Certi	ificate of	Death	R	og. No.	Gus 1	261					
	Dh i - i - i	1. Decedent's Nama (First, Middle, Last)	Ruth Naomi	McGh	nee		2. Date of Deat Month	h	Yaar 3	. Tima of Death					
ш	Physician /Medical		Itacii Itaomi				July 12	,		10:30 AM					
	Examiner	4a Facility Name (If not institution, giva : 1607 Gray Place	street end number)		4b. City, Town, or Location of Death Dundalk 4c. County of Death										
	Funeral Director	220-12-6549	7. Age (In yrs. le		If Under 1 Year Months Days		8. Date of Birth (Month, Dey, June 2	Year)	9. Birthplace Country) Mary	(Stete or Foreign					
	2 3	Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Loca	ation				10d	Inside City Limits					
	H sho	Maryland Balti				Dund	alk			1 □ Yes 2 HNo					
1	or 28a-f s	10e. Street and Number			10f. Zip Code		1	0g. Cifizen of W	het Country?						
	23a	1607 Gray Place				21222		United	States - American I						
020	n zz nours aner cean win me meryend "natural", or items 23a or 28a-f show exical Examiner must be notified at leted by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	 12. Was Decedent Evar In U,S Armed Forces? 1 ☐ Yes 凝☐ No If Yes, Give Yaar or Dates: 		13. Was Decedant of Hispanic Origin' if Yas, specify Cuban, Mexican, Pour 1 ☐ Yes 2 ☑ No Specify:		pecify Yes of No- o Rican, atc.)		, White, etc.	ite					
21215-0020	5 2 5	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give ki		pation during most of word ed)	rking	16b. Kind of Bu		Ŋ					
		10 Years 17. Father's Name (First, Middle, Last)		Home	emaker	18 Mother's Nat	me (First, Middle, I	Own Hor							
5	S s S S	Oliver Cleveland	Laing				Marian Be		,						
ary.	end Men s marke aumatic	19a. Informant's Name/Relationship (Ty		19b. Mailing	Address (Stree	t end Number or Ru			Stete, Zip Co	de)					
	0515	Mr. Roy E. McGhe	yland 2	21222											
Baltimore,	nent of Heal	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	amoval from State		tory or other ple			20c. Location - 0							
altin	Department of Important: If any injury or pace.	4 Donation Scholner (Specify) Entombment Holly Hill Mem. Gdns. 7/16/1998 Middle River, MD 21. Signature of Fuerral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.													
00 ;	20 5 2 2	7922 Wise Ave. Dundalk, Maryland													
		23a Part Ends the distant or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximete Interval Between Onset and Death													
2	hysician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	Acute 1	Pyoci	ARISI A	+2 I		4	Or	sat and Death					
	je je		ASCVD	as a conseque	ence of):				1						
9	in and itel-transit	Sequentially list conditions,		es a conseque	ence of):										
60,	cian s burial-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
ς 68760,	ing physician and assumed as the burial-transit	resulting in death) Last													
Вох	e attendin od for use sician/h														
o }	y the ached	Part II. Other eignificant conditions con	tributing to death but not resu	Iting in the und	derlying cause g	iven in Part I.	23b. Did tobecco use contributs to the cause of de: 1 Yes 2 No 3 Probably 4 Unkr								
Records,	been sign should be						24a. Was a perior		availa	autopsy findings ble prior to etion of causa					
	ate has be page 2 s						1 🗆 Y	es 250 No	1 🗆 Y						
Vital	s carificate director, pag	25. Wes case referred to medical examiner?					eth (Check only or	10)							
o d		1 ☐ Yes 25 No		ER/Outpetient	3LI DON	ther: 4 Nursing I		ence 8 Othe							
	Officer: After the funeral and funeral entitication:	27. Menner of Death 1 Neturel 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inj W	uryat ork?]Yes 2 ☐ No	28d. Describe h	ow injury occurr	ed						
Division		3 Suicide 6 Could not be determined	28e. Placa of Injury - At hos building, etc. (Specify)	me, farm, strae	et, factory, office		28f. Location (S City or Town	treet and Number, n, State)	er or Rural R	oute Number,					
(die la		lician: To the best of my knowner: On the basis of examinati and manner stated.												
1	2 × 10 × 10 × 10 × 10 × 10 × 10 × 10 × 1	25b. Signature and title of conflier	Jelled 1	1.)	29c. Licer	ise number	4 2	9d. Date signed	3-9						
	10	30. Narra and address of berson who co	11	23e) (Type, P	1)	1103	R			22/					
	State	31. Date filed (Month, Day, Year)	1612 04 Dayloson	Pandell	-H701N	111/	IHLTIN	nole/	102	224					



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Dey 12, 1998 2:55 AM ELIZABETH V. MC KINLEY JULY 4b. Cify, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) CONTINUUM CARE AT SYKESVILLE SYKESVILLE CARROLL If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) 1□ M XXF Months Deys Hours Min Yrs. 218-34-5804 87 DEC 7, 1910 MARYLAND Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No HILLSBOROUGH LUTZ 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 18824 TRACER DRIVE 33549 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Meritel Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: WHITE 3℃Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) STORE MANAGER SHOE STORE 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) JAMES IRVING PARKER JOSEPHINE GARNER 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 18824 TRACER DRIVE, LUTZ, FL 33549 JAN HAWKINS, SON 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) FLAGLER MEMORIAL PARK 7/15/98 MIAMI, FL 22. Name end Address of Fecility STERLING ASHTON FUNERAL HOME, INC. 21. Signeture of Funerel Servica Licansee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) · HEMORRHAGIC ZWKS LEREBROVASCULAR ACCUDENT Due to (or es e consequence of): CEREBROVASCULAR Due to (or es e consequença of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2€ No

Physician /Medical Examiner

signed by the a d be detached f

certificate has b lirector, page 2 s

this funeral

After t

24 hours

within 2

filled in by

Hospital or Attending s after decor. After the fu by

Completed

Be

P

Certification:

edical

P.O. Box 68760.

Division of Vital Records,

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

Funeral

Director

with the Maryland r 28a-f show

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a

Examiner physiciam and the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Physician/Medical 1 Se esn

Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

ASPIRATION PNEUMONIA

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth Neturel

2 Accident

3 ☐ Suicide

4 ☐ Homicide

5 Pending Investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 TYes 2 No

Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 28d. Describe how injury occurred

26. Place of Deeth (Check only one)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29c. License number

29b. Signetyre end title of certifier

1).46390

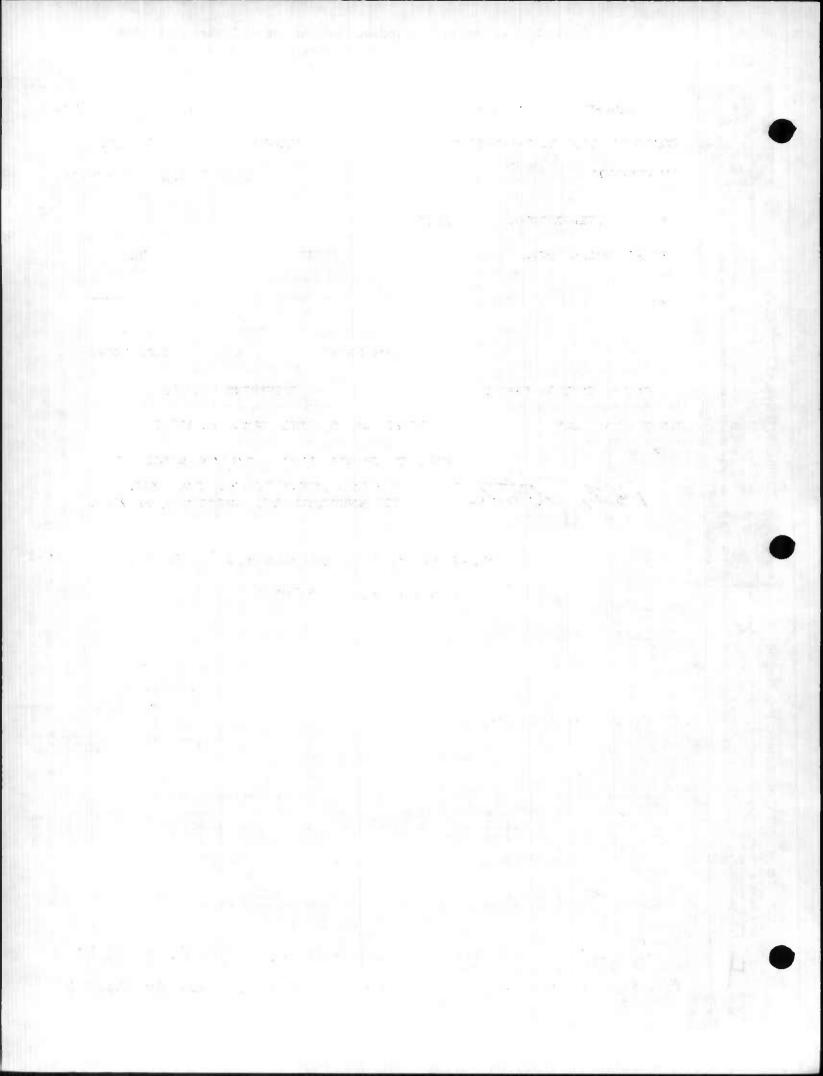
29d. Date signed (Month, Dey, Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Hospitel:

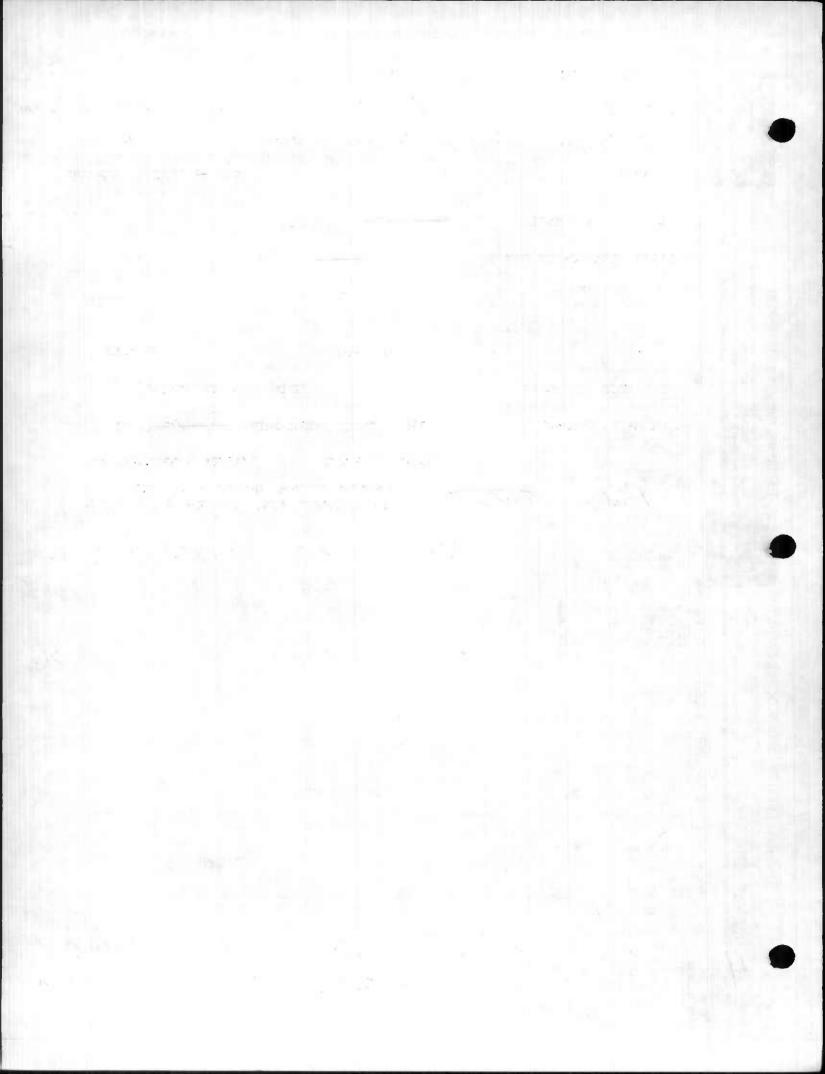
PANDALLSTONM MD 21133 P. R. DESA (ND - 5310 OLD COONT RO, # 201, 31. Dete filed (Month, Deyn Yedr) 1 4 1998 32. Registrer & Signeture Julia Davidson Randelle

State Registrar



Please Type or Print in Black Indeiibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	19b Per Informat Film G762 8-4-9 1. Decedent's Name (First, Middle, Last)	4-	ertificate of L	2. Date o	2. Date of Death 3. Time of De				
ian ical	CAROLYN	m	ACK	5015	1 12 199	8 5:36an			
ner	4a Fecility Name (If not Institution, give street end numb	DV 15- 4	low sitel	b. City, Town, or Location of C					
	5. Sociel Security Number 6. Sex 7.	Age (In yrs. last birthde	USPITOL SUNDER 1 Year	BALTIMORE If Under 24 Hrs. 8. Dete of	N/A				
	423-40-5638 1□ M 2\(\text{\$\}\$}\$}}\$}}}}}} \end{\text{\$\}}}}}}}}}} \text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$	65 Yrs.	Months Days	Hours Min. (Month	Dey, Year) 26,1932	Birthplace (State or Foreign Country) ALABAMA			
	Usual Residence of Decedent	100 City Town or	Location		25	I sod in ald other limits			
200	10a. State 10b. County	10c. City, Town or				10d. inside City Limits 1 ☑ Yes 2 ☐ No			
	FL ESCAMBIA 10e. Street end Number	CANTON	10f. Zip Code	SACOLA	10g. Citizen of Wha	43			
	11655 CLEAR CREEK DRIVE		-32526	32514	USA				
	11. Maritei Status 12. Wes Decede	ent Ever in U.S.	3. Wes Decedent of Hi	ispanic Origin? (Specify Yes o	r No- 14. Race -	American indian,			
	1 Never Married 2 Married 1 Never Married 2 Married 2 Widowed 4 Divorced Yeer or Date	⊠ No	1 ☐ Yes 2 № No	n, Mexican, Puerto Rican, etc. Specify:	Specific	White, etc. WHITE			
	15. Decedent's Education (Specify only highest grade completed)	18a. De	cedent's Usuel Occupa	ation during most of working	16b. Kind of Busin	ess/Industry			
	Elementery/Secondery (0-12) College (1-4	life	DO NOT use retired)	OLDI IIC	ME			
	12 2 17. Father's Neme (First, Middle, Last)	F	HOMEMAKER	18. Mother's Neme (First, Mi	OWN HC	ME			
	LAWRENCE SAUNDERS				HOMPKINS				
	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street	and Number or Rurel Route N		ete, Zip Code)			
	LEON MACK, HUSBAND	1165	55 CLEAR CE	REEK DRIVE. CA	NSACOLA NTONMENT, F	L 32514			
	20e. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from Sta	20b. Place of Dis	sposition (Neme of remetory or other place	Dete	20c. Location - Cit	y or Town, State			
	4 Donation 5 Other (Specify)		V CEMETERY	7/15/9	8 PENSACOLA	, FL			
	21. Signeture of Funeral Servica Licensee		22. Name and Address	ss of Fecility SHTON FUNERAL	HOME THO				
	Mully Stark			SON AVE., BALT		21228			
	23a. Part1. Enter the disease, or complications that cau shock, or heart feilure. List only one ceuse on each	used the death. Do not o	enter the mode of dyin	g, such as cardiac or respirate	ory errest,	Approximate Interval Between			
	the state of the s	11 -	- 4		1.0- 1	Onset and Death			
	Immediate Cause (Final disease or condition resulting in death)	MES	ENIER	IC INFA	IRCI ION	6 Hour,			
		Due to (or es e cons	sequence of):	BRILLATI	DN	57 NAME			
	Sequentially list conditions	Due to (or es a cons		1-10-111	0,0	1 DRY			
200	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	2544.							
	Cause (Disease or injury thet initieted events resulting in death) Lest	Due to (or as a cons							
	d	53PT	10 56	IOCK		14 DAY			
	Part II. Other significant conditions contributing to deat				\/	bute to the cause of death			
I	PANCREATIC	GANCE	=12		1 Yes 2 No 3	☐ Probably 4 ☐ Unknow			
				24e.	Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause			
						of death?			
	25. Wes case referred to medical				1□ Yes 2 No	1 Yes 2 No			
	exeminer? Hospitel:	patient 2 ER/Outpet	tient 3 DOA Oth	26. Plece of Death (Check of Plece of Plece of Plece of Death (Check of Plece of Pl		(Specify)			
	27. Manner of Death 1 Natural 5 Pending 28a. Deta of (Month,		e of 28c. Injury		ribe how injury occurred	<i>Ореспу</i>)			
	a Could not be	f Injury - At home, farm, , etc. (Specify)		28f. Locati	ion (Street and Number r Town, Stete)	or Rurel Route Number,			
	29a. Certifier Check only one) Certifying Physician: To the best end manner on the basi end manner.	is of examinetion and/or							
	29b. Signature and title of pertifier	Sun LICAL.	29c. License	e number	29d. Dete signed (Month, Day, Year)			
1	A A A A B B B B B B B B B B) COUNTY C		11 F PT	D/.	100			
		NBS WENT	1 ZHI	1-04219	////	2/98			
Medical	30. Name and eddress of person who completed cause	Sund(AL NBS DENT of deeth (Item 23e) (Typ	no Print\		///	2/98			
Me	30. Name and eddress of person who completed cause of the second of the	of death (Itam 23a) (Tyr	oe, Print)	1-04385	MORE,	MARYLAN			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Amend: #20b.c Per FH Film G761 7-23-98RC 2. Date of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Month **Physician** Jesse Montgomery 5, 5:20 A.M. July 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nema (If not institution, giva street and number) **Examiner** 2109 Poplar Grove Street Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Mooth, Pay, Year) 11-28-1936 5. Social Security Number Birthpiaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Hours Min 1 M 2 F 216-34-9312 Yrs. **Director** 61 N.C. Usual Rasidence of Dacedant with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at 1 Yes 2 No Md N/A Baltimore Director 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number 21216 2109 Poplar Grove Street USA deeth . Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Orlgin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian. 11. Maritel Status Black, White, atc filed within 72 hours efter 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry College (1-4or 5+) al Hygiena. Elementary/Secondary (0-12) Brown Memorial Church 6 grade Custodian 18. Mothar's Nama (First, Middle, Meldan Sumema) 17. Fethar's Nama (First, Middla, Last) permit. Pages 1 end 2 should be i Department of Haalth and Mental important: If tem 27 is marked of any Injury or other trsumatic eve Willie Corry James Montgomery 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Coda) Ursula Pratt- Friend 2109 Poplar Grove Street Baltimore, Md 21216 20b. Placa of Disposition (Neme of cemptery, gramatory, or other placa)
Arbutus Temporial Park 20c. Location - City or Town, State 20a. Method of Disposition 7-10-98 Randallstown Md 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Ramoval from State 4 □ Donation 5 □ Other (Specify) 22. Nama and Addrass of Facility of Funaral Servica Lie any ir March F/H West 4300 Wabash Avenue Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that causad the deeth! Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line. Approximata Interval Batwaan Onset end Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical metastatic colon carcinoma months **Examiner** Due to (or es a consequence of): Physician/Medical Examiner Sequantially list conditions, if eny, leeding to immadiata cause. Enter Undarlying Causa (Disaasa or Injury that initiated evants The law requires that the death certificate by swecut Due to (or es e consequence of) attending physician and Division of Vital Records, P.O. Box 68760, Dua to (or as a consequanca of): rasulting in death) Last signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of death? should t 24a. Was an autopsy performed? Completed page 2 s 1 Yas 2 No 1 Yas 2 No certificate or Attending Physician: 25. Wes case referred to medical examinar? Be 26. Place of Deeth (Chack only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Vo 10 1 Inpatiant 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 ☐ Panding invastigation death. 1 □ Yas 2 □ No n 24 hours after death.

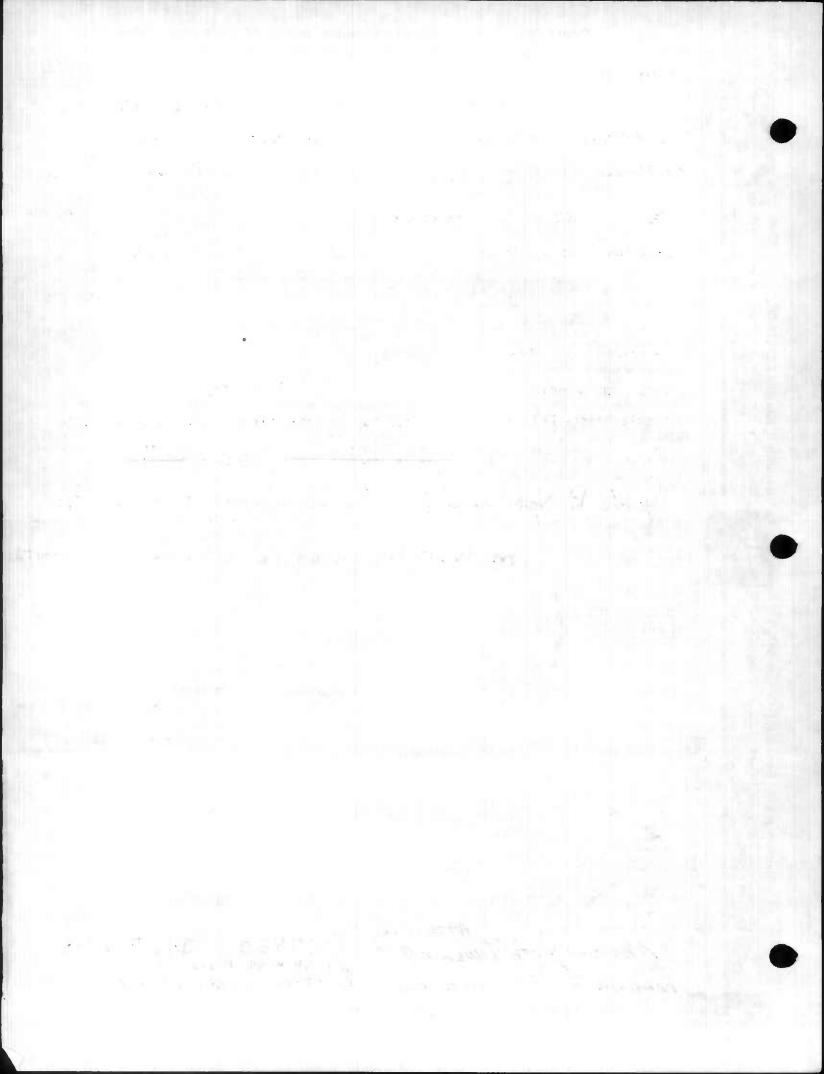
Funeral Director: Al 2 Accident 6 Could not be datarminad 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida Hospital edicai 29e. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, deta and place, and due to the cause(s) and mannar as stated 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and piece, and due to the causa(s) and manner stated. (Check only one) within 2 29d. Data signed (Month, Day, Year) 29b. Signetura end titla of certifia Attending 29c. License number 0 07930 KID 30. Nama end address of persen wh who completed causa of death (Itam 23a) (Type, Print) 301 St PAUL Plate

State Registrar MARVIN

31. Data filed (Month, Day, Year)

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FELDMAN Baltimore, Md, 21202 MAD 32. Registra & Stonature



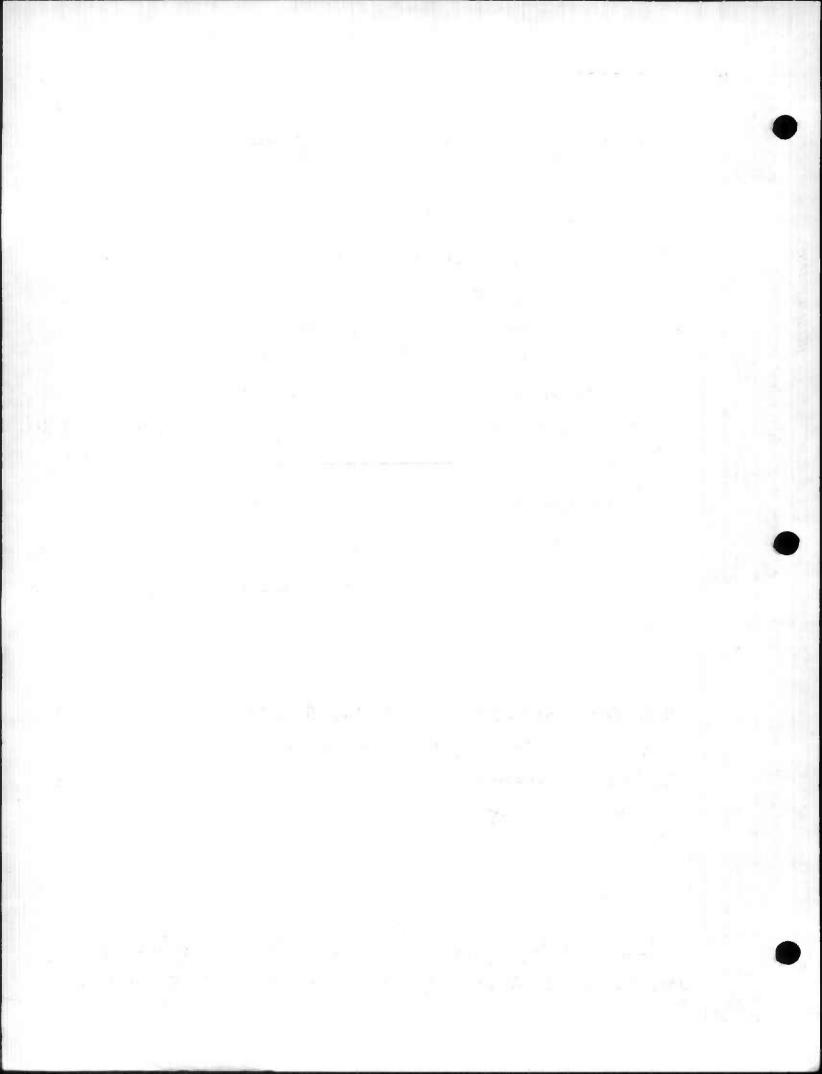
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#20b per FH G761 7/14/98 FW 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0015 AMES /Medical 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BANTIMORE UNIVERSITY of MARYLAND MEDICINE 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 215-22-8531 Usual Residence of Decedent Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1€Yes 2 No Director MD Saltimores 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 802 21217 STREE JROE Funeral 12. Was Decedent Evar In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Nem 27 is merked other than "natural", or fren any Injury or other traumatic event 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Ho Specify: þ 3 ☐ Widowed 4 ☑ Divorced Blac Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
5 TH Q RIDE
17. Father's Name (First, Middle, Last) College (1-4or 5+) EASTERN STEE IA U 18. Mother's Name (First, Middle, Meiden Sumeme) IAMES N EISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) STREET, BAITO MD & MONROE 802 DEATRICE JOHNSON 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Arbutus 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Arbutus 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee WEST INC UNERAL Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert fallure. List only one ceuse on each line. Balto Approximate Interval Between Onset and Death **Physician** RESPIRATORY Fachure /Medical Immediate Cause (Final Z Moulte disease or condition resulting in death) Examiner ICOBSTRUCTIVE Reluvery Disease Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Box 68760. ettending physicial for use as the trun Physician/Medicai Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobecco use contribute to the cause of death? 3 □ Probably 4 □ thknown 1 ☐ Yee 2 ☐ No Pulmon ARY DEDEATA by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed HYPERTENSION HYPOTHYROLDISH SEP SIS PNEUMONIA 1 ☐ Yes 2 ☐ NO 25. Was cese referred to medical examiner? Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) P 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending investigation 1 Yes 2 No 24 hours efter death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier ứ CertifyIng Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. To the within 2 29b. Signature and titla of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) DETITION HOSPITHC 611. SOUTH CHARLES ST AMESFLYNO 31. Date tiled (Month, Dey, Year) State

lia Davidson

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#25,26 per Phy G761 7/14/98 EW 1. Decadant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month William Edward Naill, Sr. June 29 1998 9:25 P.M. 4a. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Carroll County General Hospital Westminster Carroll 6. Sax 1 → M 2 □ F If Under 1 Yaar if Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Sept. 17,1928 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 69 Yrs. 220-28-8739 Maryland Usuel Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 No Carroll Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 30 Ward Ave. Box 3 21157 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 11. Marifal Status 14. Race - American Indien, Black, White, etc. OXYes 2 No 1950-1 Never Marriad 2 Married 1 Yas 2 No Specify: Specify: 3 Widowed 4 Divorcad Year or Datas: 1952 White 15. Decedent's Education (Specify only highest grede completed) 16a. Dacedant's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) Collaga (1-4or 5+) Prime Manufacturer Co. Woodworker 5th grade 17. Fethar's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) Edward Ellsworth Naill Ella Elizabeth Glass 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Naill 30 Ward Ave. Wife Westminster, MD Box 3 2.1157 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stata cemetery, crematory or other place) 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from State Bethel Church Cemetery July 3 4 ☐ Donetion 5 ☐ Other (Specify) New Windsor, MD of Funeral Service Licensee 22. Name and Address of Fecility Burrier-Queen Funeral Directors, P.A. very 1212 W. Old Liberty Road Winfield, MD 21784 Entar the disease, or complication, be or heer failura. List only one ceus death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between

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permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan Department of Health end Mental Hygiene.
Important: If tier 27 is merked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examine must be notified as

Baltimore, Maryland 21215-0020

and burial-trar the

29b. Signeture and fifle of certifier

Onset end Deeth mute Cause (Finel · Myocardial minutes resulting in death) Physician/Medical Examiner (Moderat Saquentielly list conditions, if eny, laading to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by Completed Be Certification: To Medical

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	. Wes casa raferred to medical							26. Placa of Da	ath (Check only ona)				
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	3 Suicide 6 4 Homloida	6 Could not be determined	28e.	Piece of Injury - At h building, etc. (Speci		et, fact	28f. Location (Street and Number or Rural Route Number, City or Town, Stata)						
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Hospital or Attending Physician: The law requires that the death certificate be executed

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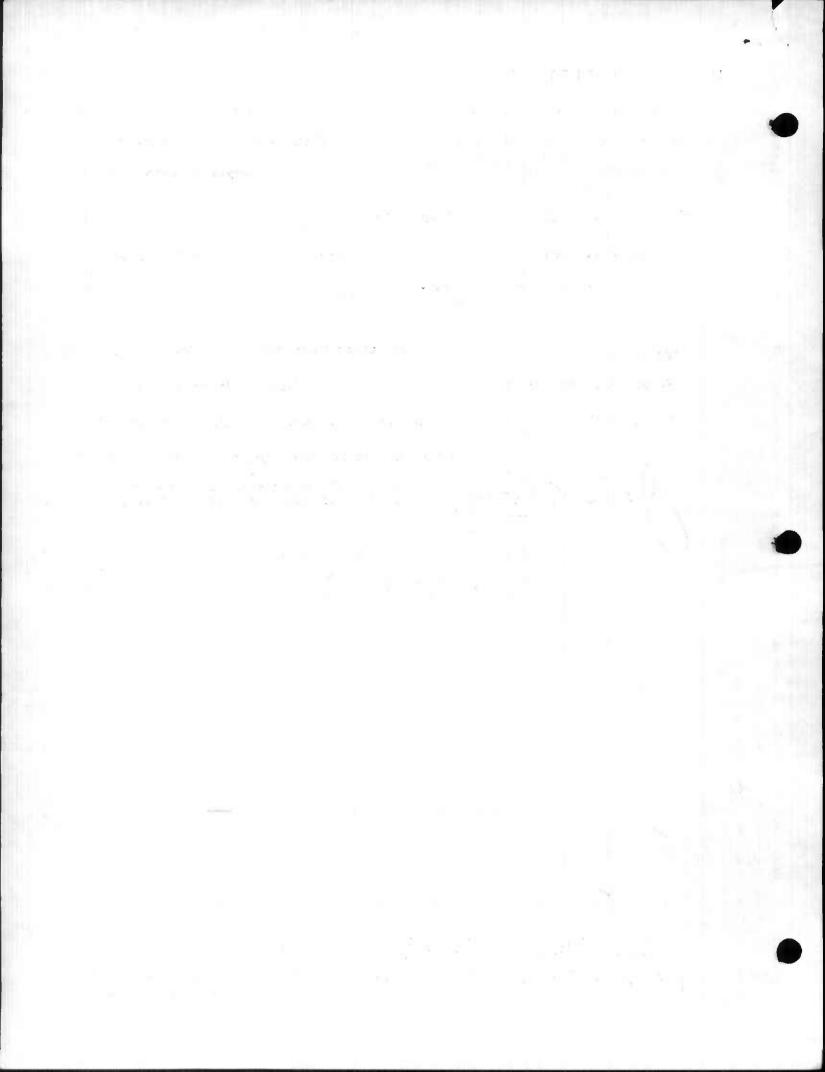
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Division of Vital Records, P.O. Box 68760,

State Registrar 30. Nema and address of parson who completed causa of death (Item 23e) (Type, Henderson 32. Registr

29c. Licensa number

29d. Date signed (Month, Day, Year)

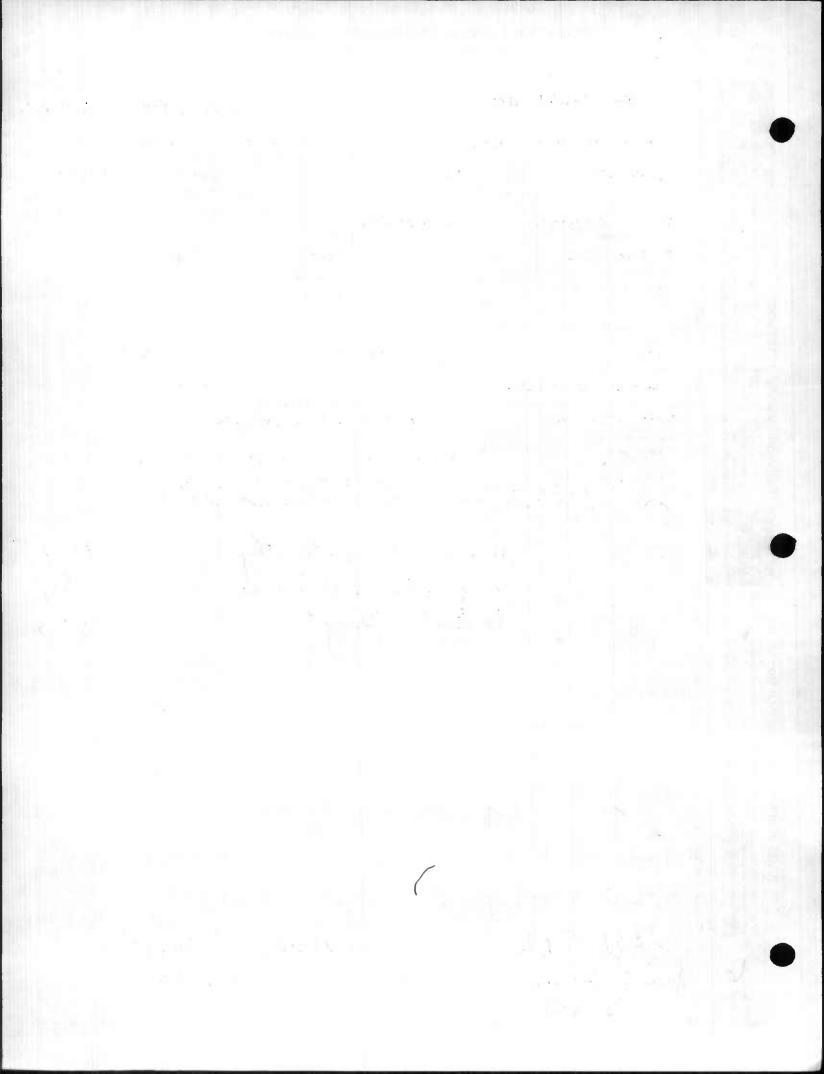


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11. Meritel Status 1 ☐ Never Meritel	erried 2 Marrie	Armed For	orces?	0,5.	If Yes, s	pecify Cub	en, Mexicer	n, Puerto	o Rican, etc.)	10-		k, White	
	4 Divorced	If Yes, Giv Yeer or D	ve letes: W N	VII	1 ☐ Yes	s 2ENo	Specify:	;			Specify:		
	15. Decedent	t's Educetion	1002	16e, Dec	ecedent's Us	Isuel Occu	pation			16b. Kind of Business/Industry			
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19e. Informent's t	Neme/Reletionsh adnuk/				ailing Addre	ess (Street Eve	end Numbergree	eror Aun en D	rel Route Num. Dr., B	alti	or Town, t	Stete, Zi e M	(ip Code) 1d 21234
		3 ☐Removel from Specify)		cemetery, ca	Plece of Disposition (Neme of cemetery, cremetery or other plece) Holy Redeemer Cem 7/								Town, State
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Sequentially list of eny, leading to cause. Enter Unc Ceuse (Disease other initiated even resulting in death	immediete iderlying or Injury nts	b	Due to	o (or es e cons	sequence o	of):		-/	17	70-1			
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MET	4 STA	TIC	Pri	OSTA	TE	Ca	ARC 16	Jon	14	Yes 2	1	T	Obably 4 Unknown
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									10	Yes 2	De la constante de la constant	1	1 □ Yes 2 KNo

Physician /Medical **Examiner**

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the bundransit To the Hospital or Attending Physician: The law requires that the death certificate be see within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician at

Division of Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Examiner Medicai Certification: To

Directo Md

by Funeral

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Be To

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinet must be notified at once.

Baltlmore, Maryland 21215-0020

25. Was ces exeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Neturel 1 Yes 2 No

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated.

| Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. 29d. Date signed (Mogth, Dey, Year)

29b. Signeture end title of certifier

29c. License number

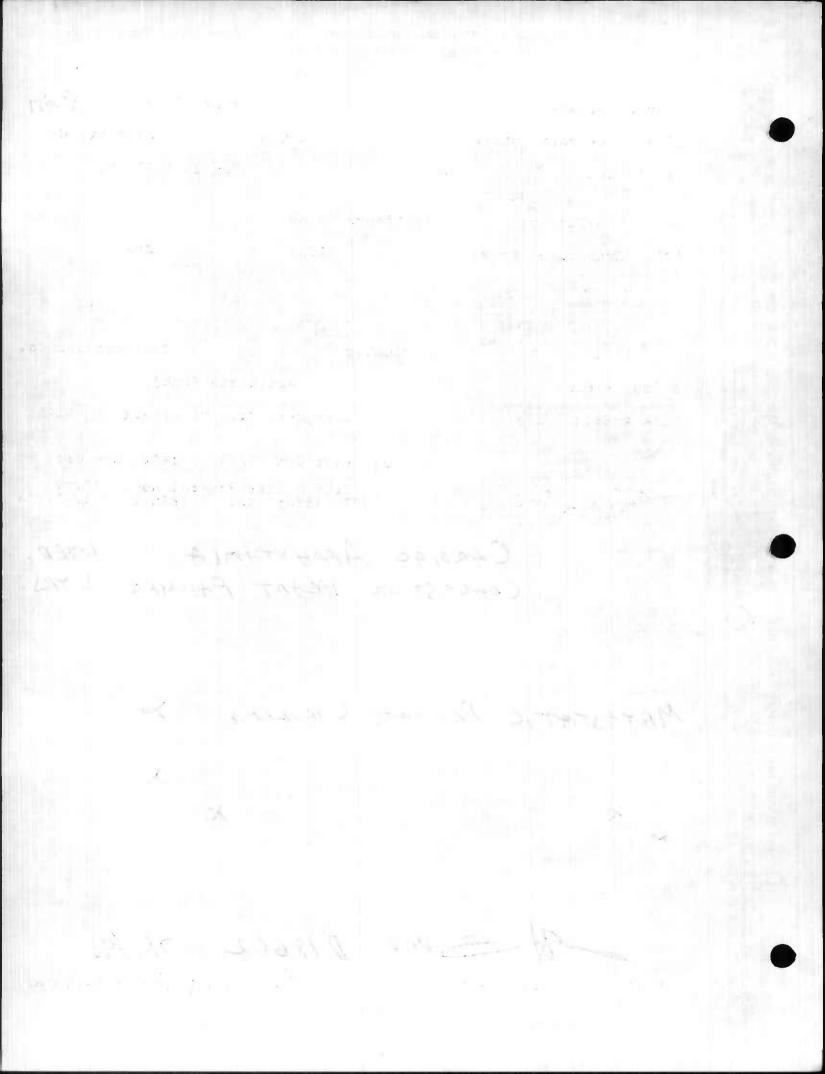
30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

WM

31. Dete filed (Month, Day, Year)

32. Registrar's Signature Sulia Davidson

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 13, 1998 WU 5:00 am BARNEY RUTH 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street end number) 4c. County of Death altimore tospital tranklin enter Mare 8. Dete of Birth (Month, Dey, Year) July 27,1927 If Under 1 Year 5. Social Securify Number (In yrs. lest birthday) 6. Sex Birthplace (State or Foreign Country) Deys 10 M 2 F Months Hours Min. 217-20-6669 70 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits Md. Baltimore Essex 1 ☐ Yes 🗶 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whef Country? 1148 East Riverside AVe, 21221 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2√ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Carlin National Bottleing Department 5th 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Henry Ruth Anna Morgan 19e. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Winifred Lingelbach 811 Norris Lane BAltimore Md. 21221 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State SacredHeart of Jesus 7/16/98 Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funerel Service Licensee Connelly Funeral Home of Essex 23a. Part1. Enfer the disease, or complications that caused the death. Dynaf enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximete interval Between Onset and Deeth 20 Minutes Immediate Cause (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown Heart 24b. Were autopsy findings evaileble prior to 24e. Wes en eutopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No 26. Plece of Deeth (Check only one)

Physician /Medicai Examiner

Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylei Department of Health and Mentel Hygiena. Important: if itsm 27 is marked other than "natural", or itsma 23a or 28a-f show any injury or other traumatic avent, the Medical Examination must be neutred as

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physician and the bunal-transit esn

Examiner Physician/Medical Completed Medical Certification: To

Division of Vital Records, P.O. Box 68760 After this certificate a or Attending Physician: T safter death. i Director: After this certifical

Puneral To the within 2 0

> State Registrar

31. Date filed (Month, Dey, Year)

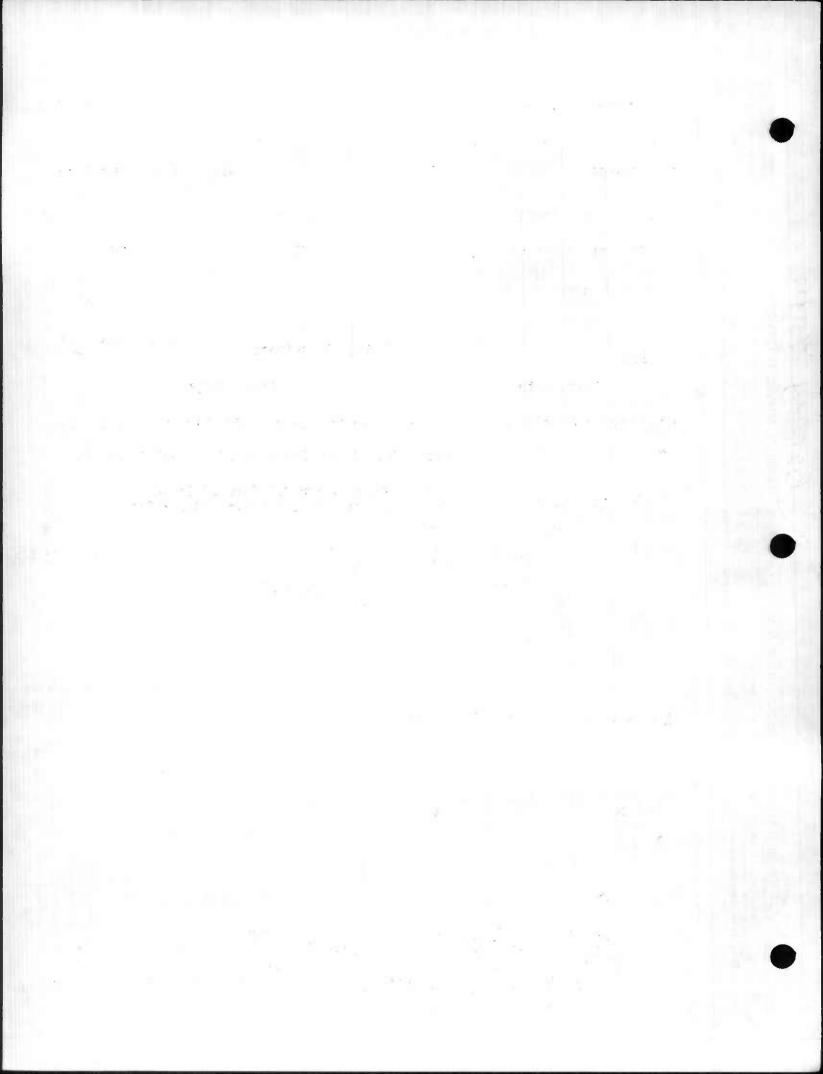
25. Was case referred to medical exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide 12 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) and menner as stated.
2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie

29d. Dete signed (Month, Day, Year) 29c. License number D3868 7

9000 Franklin Square Drive Baltimore, Maryland 21237

Beeth (Item 23e) (Type, Print) STEPHEN MD.

JUL 1 4 1998



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** JUMPH 1 2 ey 1998 OCIE ANN 9:15am /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 306 Savannah Road Essex Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | N O V • 17 , 19 17 5. Social Security Number 220 - 24 - 7120 9. Birthplece (State or Foreign Westerny inginia 7. Age (In yrs. lest birthday) **Funeral** 1□ M 2⁄□ F Yrs. 80 Director Usual Residence of Decedent the Merylend 10a State 10h Counts 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Moulcal Examiner must be notified at Md. Baltimore Essex 1 ☐ Yes X□ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 306 Savannah Road 21221 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Reca - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental Hygiena. If them 27 is merked other than "natural", or iter any injury or other traumatic awant 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: White þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) School Cafeteria Baltimore County 12th 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Elbert Morgan Eliza 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) David Reed / son 2205 Old Joppa Road Joppa Md. 21085 20b. Place of Disposition (Name of cametery, cremetery or other place)
Gardens of Faith 20a. Method of Disposition Data 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 7/15/98 Rossville Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerei Servica Licensee 22. Name end Address of Fecility Connelly Funeral Home of Essex 23a. Pert1. Enter the disease, or complications that caused the deeth Do not antar the mode of dying, such as cerdiac or raspiretory errest, shock, or heart feilure. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final . Heute my ocardial in Farction Immediate diseese or condition resulting in deeth) Examiner Examiner Coronary heart disease therosclerotic pue Sequentielly list conditions, if eny, leeding to immediate causa. Entar Underlying Cause (Diseese or injury that initiated avents resulting in deeth) Lest Box 68760. attending physician Physician/Medical the Due to (or es e consequence of): P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Pibrosis of Vital Records, 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? Mild nitral stenosis certificate has 25. Wes case rafarred to medicel exeminer? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 26. Plece of Daeth (Check only ona) Hospitel: 1 inpatient 2 ER/Outpetient 3 DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 27. Mannar of Deeth 28e. Dete of Injury (Month, Dev Yeer) 28b. Tima of 28d. Describe how Injury occurred Medical Certification: 28c. Injury at Work? 5 Pending investigation 1 Neturel hours after death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicida 28f. Location (Streat and Number or Rurel Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, fectory, offica building, etc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifian 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) end menner steted. (Check only one) 29b. Signeture end titla of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Belitt. D00337 July 14, 1998

1838 Greene Tree Rd St535 Balto Md21208

Registrar

State

30. Neme end eddrass of person who complated cause of deeth (Itam 23e) (Type, Print)

Henry

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JUL 1 4 1998

of page on who completed at the Dispersion of the Dispersion of the Dispersion of the Dev. Year)

1 / 1998

98-3870-035 Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene JAMES BERGEN ENSOF#23 PART I, 27, PER MEO FILM G761 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death 1998 Month **Physician** 1730 PM James Bergen Roof JULY 6, /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner OUEEN ANNES Stevensville -CHESTER ROUTE# 8 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplaca (Steta or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**⊠** 2□ F 141-24-0772 66 Yrs Director Aug. 10, 1931 Ohio Usual Rasidence of Dacedant with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. insida City Limits rail, or items 23s or 28s-f show Examiner must be notified at Queen Anne's Stevensville 1 Yas 2 XX Md. Director 10e. Street and Number 10f Zin Code 10g. Citizan of What Country? 120 Congressional Drive 21666 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vinent of Health and Mental Hygiene.
Int: If item 27 is marked other than "naturef, or items 23 into other traumatic event, interest at the result of the Funeral 14. Raca - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Nes 2 ☐ No If Yes, Giva Yaar or Datas: 1 Nevar Married 2K Married 1 Yas 2 ₩ Specify: Specify: White q 3 Widowed 4 Divorced Completed 15. Decedent's Education (Spacify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry U.S. DEPT. Elementery/Secondary (0-12) College (1-4or 5+) Agriculture Economist in Cooperatives 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middla, Last) Bergen Joe Roof Mary Elizabeth Hoy 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Mrs. Erika E. Roof (Wife) 120 Congressional Dr., Stevensville, Md. 21666 July 10,1998 Location - City or Town, Stata 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition important: If its any injury or o once. 1 Burial 2 Demation 3 Ramoval from Stata Chesapeake Cremation Center Stevensville, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22.Name and Addrass of Facility Fellows, Helfenbein & Newnam Funeral HOme 106 Shamrock Rd., Chester, Md. 21619 is that caused the Math. Do not entar tha mode of dying, such as cardiac or respiratory arrest, Approximete Intarval Between Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition rasulting In daeth) /Medical a. ATHEROSCLEROTIC CARDIOVASULAR DIEASE Examiner Dua to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury Dua to (or as a consequence of): Box 68760. that initiated avants resulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? should I 24e. Wes en eutopsy performed? Completed i certificate has b to Yes 2 □ No 10 Vas 2□ No or Attending Physician: Be 25. Was casa rafarred to madical axaminar? 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Rasidanca XXOthar (Specify) AT SCENE Hospital: Certification: To No 2□ No 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 28a. Data of injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Mennar of Daath 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding 1 Yas 2 No death. invastigation 2 Accident ector: by the 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Sulcida Plece of Injury - At homa, farm, straat, fectory, office building, atc. (Spacify) Direc 24 hours after Funeral Direct pletaly filled in b 4 Homicide edical 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

XX Medical Examinar: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiai To the Hosp within 24 hou To the Fune completaly fi (Check only one) 29d. Data signed (Month, Day, Yaar) 29b. Signatura and title of certifian 29c. Licansa numbar

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

7, 1998

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Registrar

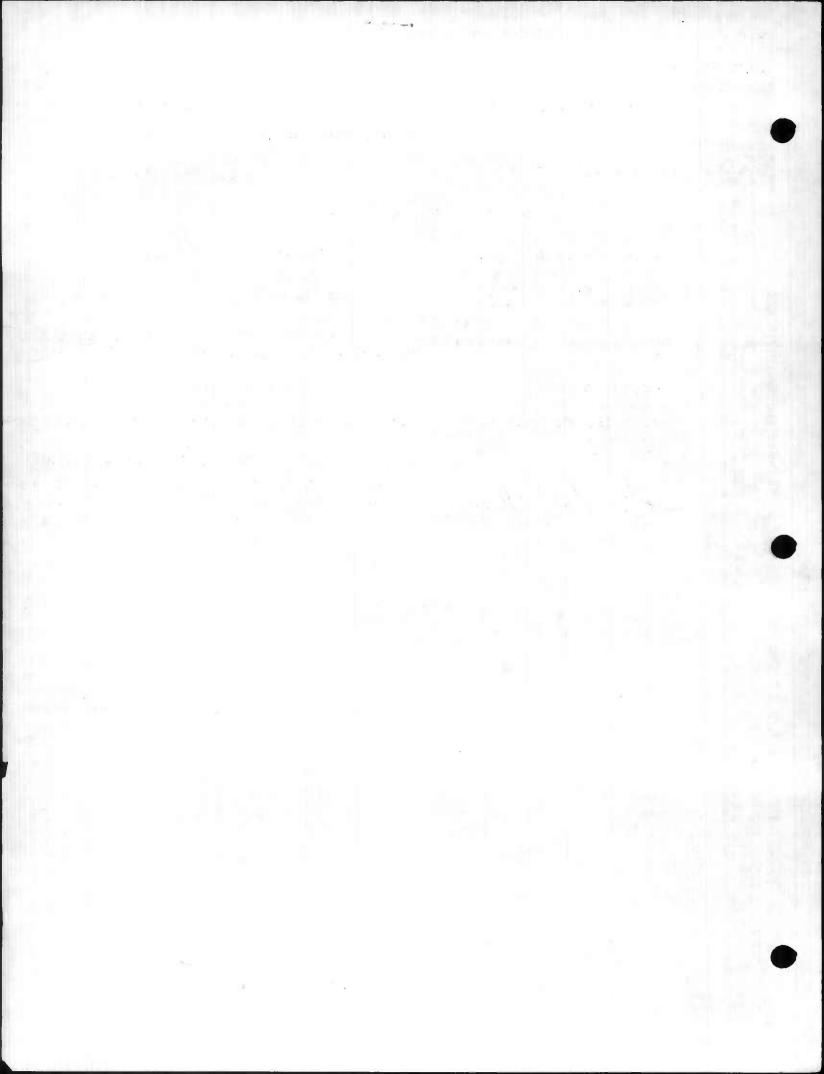
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Chute Dennis 2. Registrar's Signature
Wandson Gondall

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth TTER 1998 JUNE Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth ge (In yrs. lest birthday) If Under 1 Year Months Deys H Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day MARYLAND TIMORE OF 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Deys 1 M 2021 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2010 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Rece - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. pg NOT use retired) ONLY ONLY The Management of the service of the 15. Decedent's Education ify only highest grade completed) 16b. Kind of Business/Industry condary (0-12) College (1-4or 5+) irst, Middle, Lest)

19b. Mailing Address (Street end I

20b. Place

1 Burlel 2 Cremetion 3 Removal from Stete

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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Vogel

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32. Registrar's Signeture

4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service License

Physician /Medica

Physician

/Medical

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, its Medical Example must be notified as

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been signed by should be detac within 24 hours after death To the Funeral Directors: completely filled in by the

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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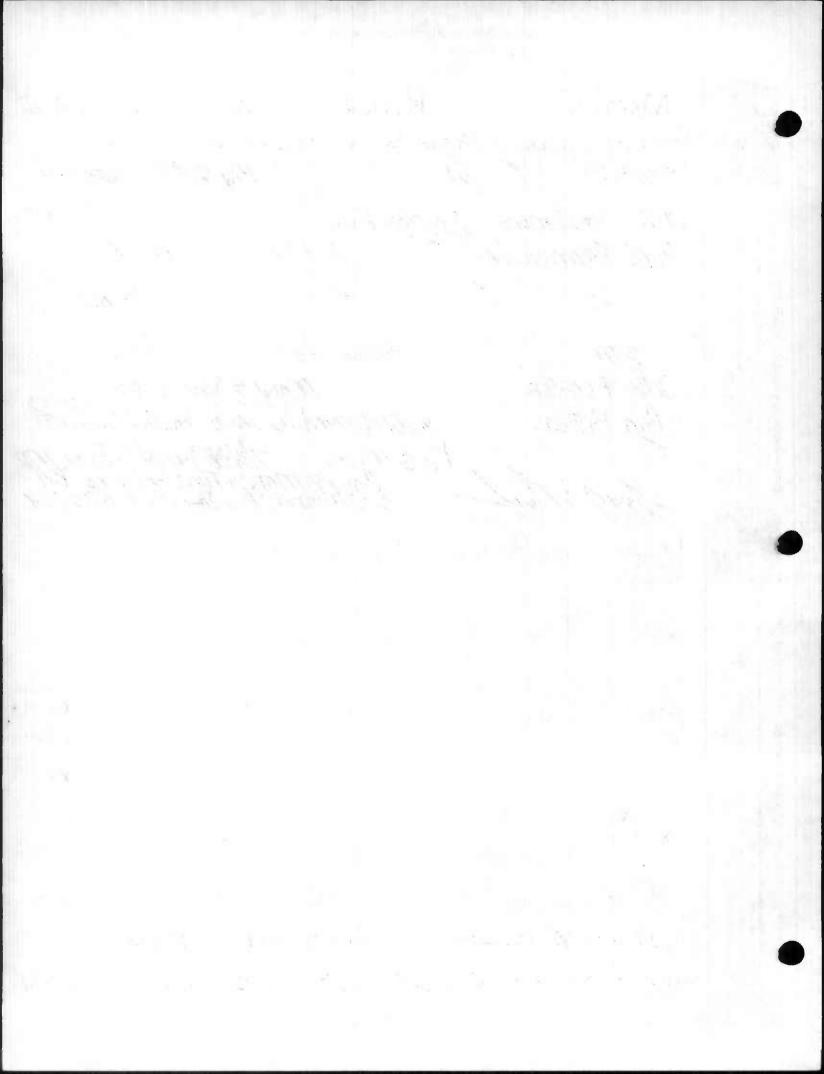
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Completed by	RHEUMATIC 1	24a Was an autonou							utopsy findings e prior to ion of cause ?	
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Certification:	27. Manner of Deeth 1 Naturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Injury (Month, Day Year)	28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? M 1 □ Yes 2 □ No					8d. Describe how Injury occurred		
erinc erinc	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, fectory, office bullding, etc. (Specify)					8f. Location (Street end Number or Rural Route Number, City or Town, State)			
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M	29b. Signeture and title of certifier	on In		29c. L	icense number # D 3452	24	29d. Dete signe 7/8/9	d (Month, Dey, 1	Year)	

GREENE STREET BALTIMORE, MARYLAND 21201

DHMH 16 Ray 6/95

State Registrar Robert

31. Dete filed (Month, Day, Year)

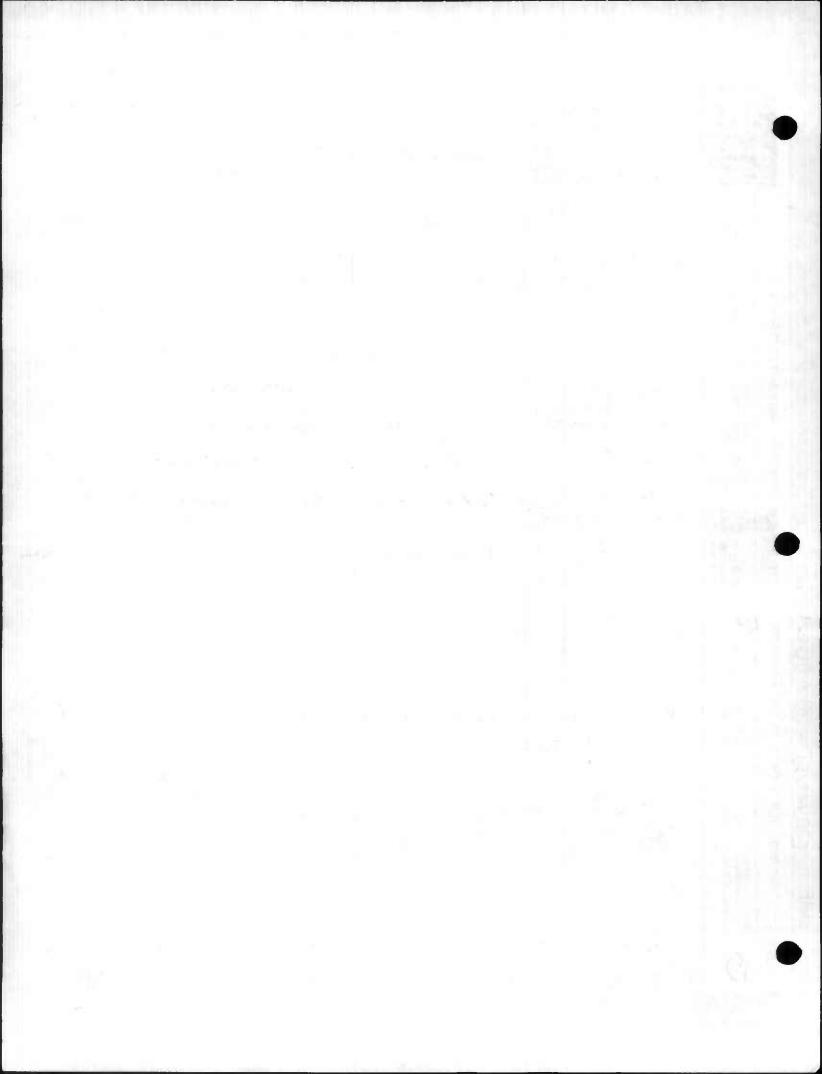


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	Physici /Media		Ernest Radoci							Toly	11	1998	5	00 pm	
	Examir		4a. Facility Neme (If not institution, giv	a street and number)				4	b. City, Town, or	Location of Dea	of Death 4c. County of Death				
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	Funeral		5. Sociel Security Number 6. S	iex 7. Ag	e (In yrs.	last birthda	y) If Und Month	er 1 Year S Days	1 Year If Under 24 Hrs. 8 Days Hours Min.		rth	9. Birthp	lece (Stata	or Foreign	
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	d 2 should be filed within 72 hours efter death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at	ō	1.500.000			timor						Ι.		2 No	
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alt	permit. Peges 1 and Depertment of Heelth Important: If item 27 any injury or other tr once.		Jackson Cemetery 7/15/98 Shenandoah, Viz 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Witzke Funeral Homes, Inc.												
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	/Medicai Examiner		Immediate Cause (Final disease or condition	P	eur	hom	4						100	eek	
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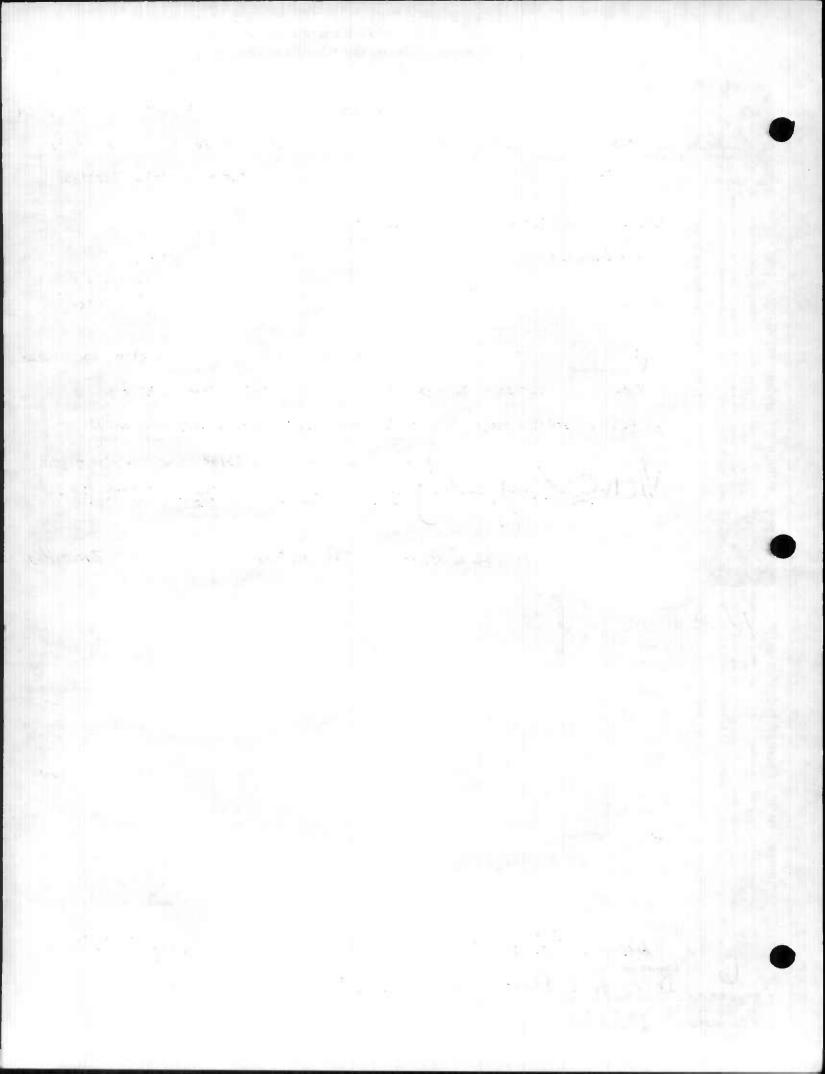


Please Type or Print in Biack indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 540 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey **Physician** July 12, 1998 Zennie Sellers 12:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Robosson Court Nursing Home Randallstown Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1 ☐ M 2 🖾 F Months Yrs. 85 Director 227-03-8838 March 26, 1913 Virginia Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Randallstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter death with neat of Health and Mental Hygiene.

Interfile T is marked other than "natural", or items 23a or ury or other traumatic event, The Madical Experient must be 4511 Robosson Road 21133 8 U.S.A. Funer 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 05 n/aRayon Department Reeling Industries 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Emmet Marion Montgomery Lula Mae Fuller 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mrs. Nettie Ford/Daughter 12 Harding St., Timonium, Maryland 21093 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Dete 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or or 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 7/15/98 4 Donation 5 Other (Specify) Pine Grove Cemetery Rayville, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc 10 West Padonia Road Timonium, MD 21093 Lengrand, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Coronary Thrombosis Zmontas disease or condition resulting in death) Examiner Due to (or as e consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 The law requires that the death certificet Due to (or as a consequence of) 23h. Did tobacco use contribute to the cause of death? by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 donknown þ 24b. Were autopsy findings available prior to completion of cause of death? should b 24a. Wes en eutopsy performed? Completed ate has t 1 Yes 2 ₽No 1 Yes 2 No certificate or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Universing Home 5 Residence 8 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this : After this 28d. Describe how Injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 DNetural 5 Pending 1 ☐ Yes 2 ☐ No death. filled in by the fr investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. pletely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) borah 32. Registrar's Signature 31. Date filed (Month, Day, Year) State which Davidson. Registra IIIL 1 4 1998

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend: #1 Per MD Film G761 7-24-98RC 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MOY SOOK SO JULY 10, 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF Days Yrs. 213-39-8402 62 **Director** Korea Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10799 Hickory Ridge Rd. Apt 210 21044 Korea Funeral 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2X No If Yas, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian. Black, White, atc. filed within 72 hours after Hygiena. 1 Never Married 2 Married 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic permit. Pages 1 end 2 should be file Department of Haelth end Mental Hy Important: If fem 27 is marked oths any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) No Ki Hyun Jung Ki Sang 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hak Hong/husband 10799 Hickory Ridge Rd Apt 210 O Columbia, MD 21044
20c. Location - City or Town, State 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/13/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service bicenser 22. Name and Address of Facility
Cremation Society of Maryland, Inc. Amalo 299 Frederick Road Dawn F. McDonald Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** MYOCALDIAL INFANCTION /Medical Immediate Cause (Final disaasa or condition resulting in deeth) **Examiner** I OWER GASTADIATESTINAL BUGGOING Physician/Medical Examiner physician and the burial-transit Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by t 1 Yes 2 No 3 Probably Unknown LIVER FAILURE AMALO100515 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peen completion of ceuse of death? has 2 No 1 ☐ Yes No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completaly filled in by the funeral director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ppalient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 27. Manner of Beath 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

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State
Registrar

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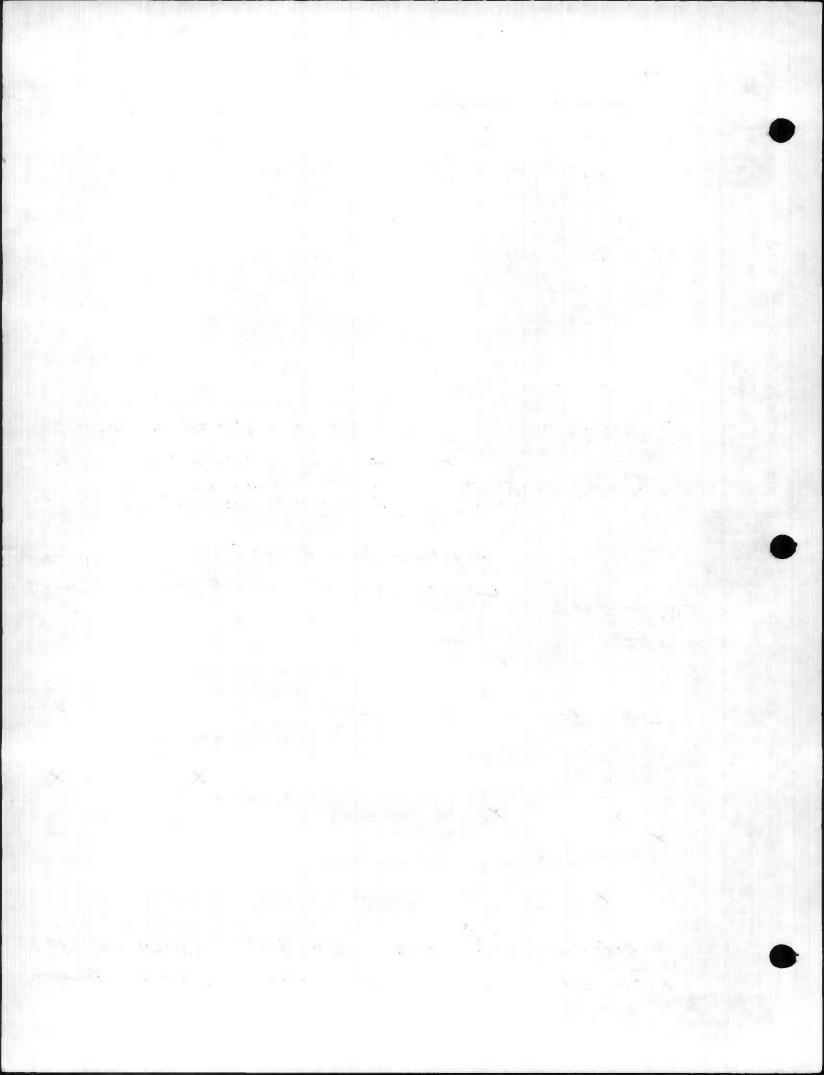
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30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print)

30 Registrar's Signature

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JOHNS HOPKINS HOSPITAL



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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedant's Nama (First, Middle, Last) Glenn Webster Sheeley 0,1998 City, Town, or Location of Deat 4a Eacility Name (If not institution, give street and number) 4c. County of Death ltimore Hes anklin anare If Under 24 Hrs. If Undar 1 Yaar 5. Social Security Number 6) Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Months Days 1 1 M 2 □ F 213-07-8959 101 Sept. 23,1896 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 10 Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6522 Cleveland Avenue 21222 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, atc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Nidowed 4 Divorced WWI White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15, Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 Years Steelworker Steel Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William H. Sheeley Ida G. Gernand 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn L. Wolfe 6522 Cleveland Avenue Dundalk, Maryland 21222 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, crematory or other placa) Date 1X Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 7/13/1998 Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signatura of Funaral Sarvice Licansae I-Suks 7922 Wise Ave. Dundalk, Maryland 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) 0 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2000 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 2 1 No 26. Piace of Death (Check only one) Hospital:

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Funeral

Director

28a-f

an "natural", or items 23s or Medical Examiner must be

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The Maryla

filed within

Pages 75

Mental

Num 27

Examiner physician and s the burial-transit Physician/Medical 60 USB o signed by the a þ Completed s certificate has b director, page 2 s Be To

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Attending Physician: this

24 h Fun within 2 To the

> State Registrar

Certification:

edical

(Check only one)

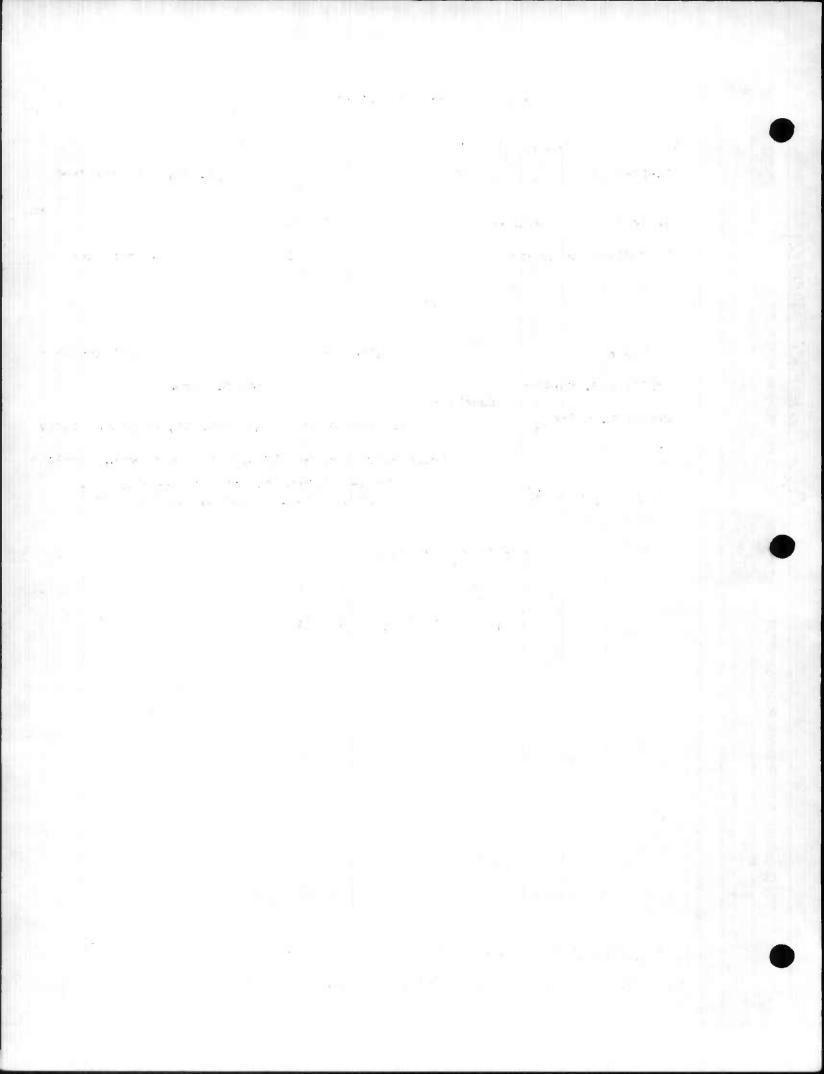
25. Was case referred to medical examiner? 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 3□ DOA 2 ER/Outpatient 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifia 29c. Licansa number 29d. Data signed (Month, Day, Year)

completed cause of death (item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Janet =35 AM Spicer July 1998 10 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Columbia Howard County Hospital General Howard If Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Social Security Number If Under 1 Yeer 9. Birthplece (State or Foreign Country) Ohio 7. Age (In yrs. last bilthday) Months 1 ☐ M 2 🖾 F 301-28-1391 Usual Residence of Decedent 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 ∏ Yes 2 THO Columbia Maryland Howard 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? U.S.A. 21044 5715 B Harpers Farm Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 🖾 Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)Home Day 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) Child Care Care Provider 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Lucy Dunn Reed Ramsdell 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) Lesley L. Wood / Daughter 6582 River Run Columbia, Maryland 21044 20b. Pieca of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriei 2 ☑ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore/Washington Crem7/12/98 Laurel, Maryland 21. Signeture of Funerei Service Licensee 22. Name end Address of Fecility Witzke Funeral Homes, Inc. Rel 1630 Edmondson Ave Catonsville, Maryland 21228 23a. Pert1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tellure. List only one cause on each line. Approximete Interval Between Onsel and Deeth Immediete Ceusa (Final Sudden death diseese or condition resulting in death) Ventricular

Physician /Medical Examiner

a signed by the

Deed

After this certificate

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

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Completed

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Certification:

edical

Physician

/Medical

Examiner

10a Stata

Director

Funeral

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7 Is marked other than "natural", or Hems 23s or 28s-f show traumatic event, the Modical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Introcrant: If Item 27 Is marked other than "natural", or item any Injury or other traumatic axes.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

death with the Meryland

Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest ettending physiclan for use es the buria Physician/Medical

Due to (or es e consequenca of)

Intlevenzao meningetis Pert II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Pert I. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en autopsy performed?

blood transfusion 25. Was case rafarred to medical examiner?

26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury et Work? 28d. Describe how injury occurred

Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Neturei 5 Pending investigation 2 Accident 3 Suicide 6 Could not be datamined 4 Homicide

Jane

1 ☐ Yes 2 ☐ No Pleca of Injury - At home, term, street, fectory, office building, atc. (Specify)

28b. Time of

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

2 NO

29a. Certifian (Check only one)

1 Yes 2 No

12 Certifying Physician: To the best of my knowledga, deeth occurred at tha tima, data end plece, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, daath occurred at the time, data end placa, and due to the ceuse(s) end menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

29b. Signeture and title of certifier

24b. Were autopsy findings available prior to

completion of cause of death?

1 ☐ Yes 2 ☐ No

State Registrar

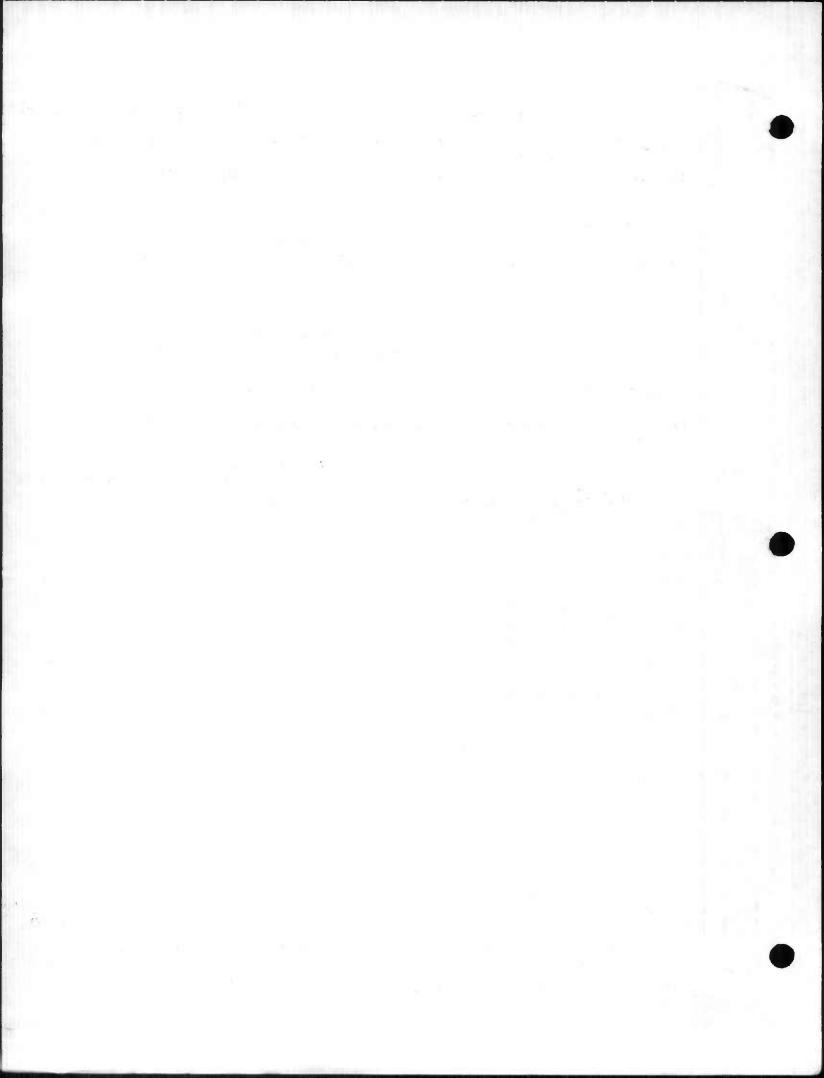
30. Neme end eddress of person who completed causa of deeth (frem 23a) (Type, Print) HO-LAI FENG, M.D

Two Knoll North Dr. Columbia, MD 21045

32. Registreria Signature Randage

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Shipley Marie Elizabeth Month 3:00 AM ULU 13 4e. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore St. Agnes Hospital If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) Days 1 ☐ M 2 🔀 F Vrs 160-18-4527 PA. July 14 1920 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yas 2 No Catonsville Baltimore 10e. Street and Number 10g. Citizan of What Country? 10f. Zlp Code U.S.A. 21228 717 Maiden Choice Lane, St. Ch.#323 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 1 Nevar Merried 2 Married 1 ☐ Yes 2 XNo If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☑ No Specify: white Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busineas/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) U.S. Government administrative assistant 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Mary Susan Loughrey William J. Kane 19e. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Murphy 10739 Lakespring Way, Cockeysville, Md. 21030 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Ramoval from State Dulaney Valley Cemetery 7/16/98 Timonium, Md. 4 □ Donetion 5 ☑ Other (Specify) Entombment 21. Signatura of Funerei Service Licansee 22. Nama and Address of Fecility Witzke Funeral Home, Inc. remmer 1630EdmondsonAve., Catonsville, Md. 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth End stage Ethronic Obstructive Pulnonary deserge Immediate Ceuse (Finei Years disaese or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Diseese or injury that initieted events rasulting in deeth) Lest Due to (or es e consequence of): Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24e. Wes en eutopsy performed? 24b. Were autopsy findings evailable prior to completion of causa of deeth? 1 Yes 2 No 1 Yes 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospitei: 1 I Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 28c. injury et Work? 28e. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide

28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

Box 68760 FLIZABETH Records, P.O. Vital # or A To the Hospital within 24 hours a To the Funeral C

Physician

/Medical

Directo

Funeral

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Completed

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Examiner

Funeral

Director

7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

I filed within 7 I Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traument

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification:

4 - Homicide

29e. Certifia: (Check only one)

the Maryland

Baltimore, Maryland 21215-0020

State Registrar 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) MUTOMBO KANKONDE

ACMES HOSPITAL ST

1 Scertifying Physicien: To the best of my knowledge, death occurred et the time, dete end pieca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred et the time, deta and piece, and due to the cause(s) end menner steted.

29c. Licansa number

D46704

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

29b. Signature and title of certifiar

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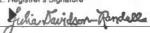
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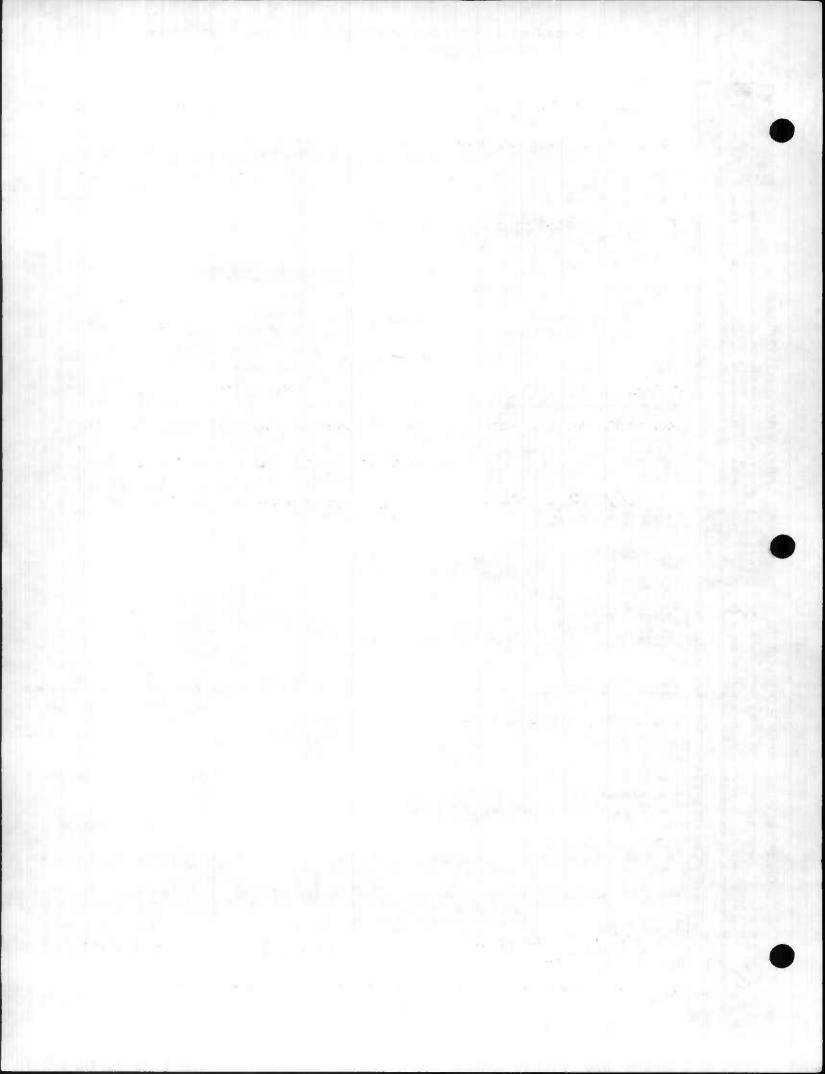
State of Maryland / Department of Health and Mental Hygiene 546 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Day **Physician** Ralph F. Shangraw July 10:15 AM 1998 10 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland
5. Sociel Security Number 6. Sex Baltimore Medical Center If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** 1X M 2□ F Months Days 68 Director 009-20-3709 June 11 1930 Vermont Usuel Residence of Deceden filed within 72 hours after deeth with the Maryland 10d. Inside City Limits 10e Stete 10b Counts 10c. City, Town or Location show r than "naturel", or items 23s or 28s-f show the Medical Example; must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1313 Biddle Court Funeral 21228 U.S.A.

14. Reca - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) University Of Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. 5+ Professor Emeritus Maryland Pharmacy 7 is marked other traumatic event, i permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe eny injury or other traumatic event, bace. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) William B. Shangraw Gladys Billings 19e. Informent's Neme/Reietlonship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1313 Biddle Court Catonsville, Maryland 21228 Marilyn M. Shangraw/ Wife 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetery or other pleca) 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Washington Crem 7/12/98 Laurel, MD 22. Name and Address of Fecility
Witzke Funeral Homes, Inc. 21. Signeture of Funerei Service Licenses 1630 Edmondson Ave Catonsville, MD 21228 23e. Pert1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medicai Immediete Ceuse (Finei diseese or condition resulting in death) Pulmonary Fibrosis Examiner Due to (or as e consequenca of) Examiner The lew requires that the death certificate be attacked ettending physicien and for use as the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) signed by the e Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert fl. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Coronary artery disease p 24b. Wera eutopsy findings available prior to completion of cause of deeth? should Completed 24a. Wes en eutopsy nis certificate has 1 Nes 2 No 1 Yes 2 KNo Hospital or Attanding Physician: 24 hours after death. 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Certification: To this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident Director: / 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aff To the Funeral Di completely filled in 156 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete and pieca, and due to the cause(s) and menner stated. 29e. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) le mo July 10, 1998 P10224 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Stoller mo 10 S. Greene St. Baltimore, MD Flizabeth 31. Date filed (Month, Dey, Year) 32. Registrer's Signature

State Registrar JUL 14 1998





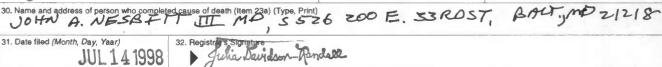
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of the Month Year **Physician** 12:32 M 13, Raymond Stinson Jul v 1998 W. /Medical 4b, City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner 5504 Morello Road Baltimore HU r 1 Y Il Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months 1 X M 2 □ F Yrs. 220-03-5770 Director 81 2-14-1917 Maryland Usual Residence of Decedent the Meryland 10c. City, Town or Location 10d. Inside City Limits "natural", or itema 23a or 28a-f ahor edical Examiner must be notified at 1 X Yes 2 No Directo Maryland N/A Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5504 Morello Road 21214 United States death Funeral 14. Race - American Indian Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 X Married ☐ Yes 2 🕱 No f Yes, Give Maryland 21215-0020 1 Yes 2 No Specify: Specify: Š 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Construction i. Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: If Item 27 is marked other talury or other traumatic evant, iii 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Malden Surname) Be Raymond C. Stinson Catherine Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 5504 Morello Road Baltimore, MD 21214 Mrs. Laura I. Stinson / Wife altimore. 20b. Place of Disposition (Nama of camatary, crematory or other place) 20c. Locetion - City or Town, State 20a. Method of Disposition 1 X Burlal 2 ☐ Cremation 3 ☐ Removel from State permit. Page Depertment of Important: If any Injury or page. 7-17-98 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Balto., MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** T-CELL LEUKEMIA/LYMPHOMA 4MO. /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? DIABETES MELLITUS 1 Yee 2 No 3 Probably 4 Unknown Vital Records, ð 100 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours Furnaral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edicai 29a. Certifier To the Hos within 24 ho To the Funcompletely (Check only one) end manner stated. 29d. Date signed (Month, Day, Year)

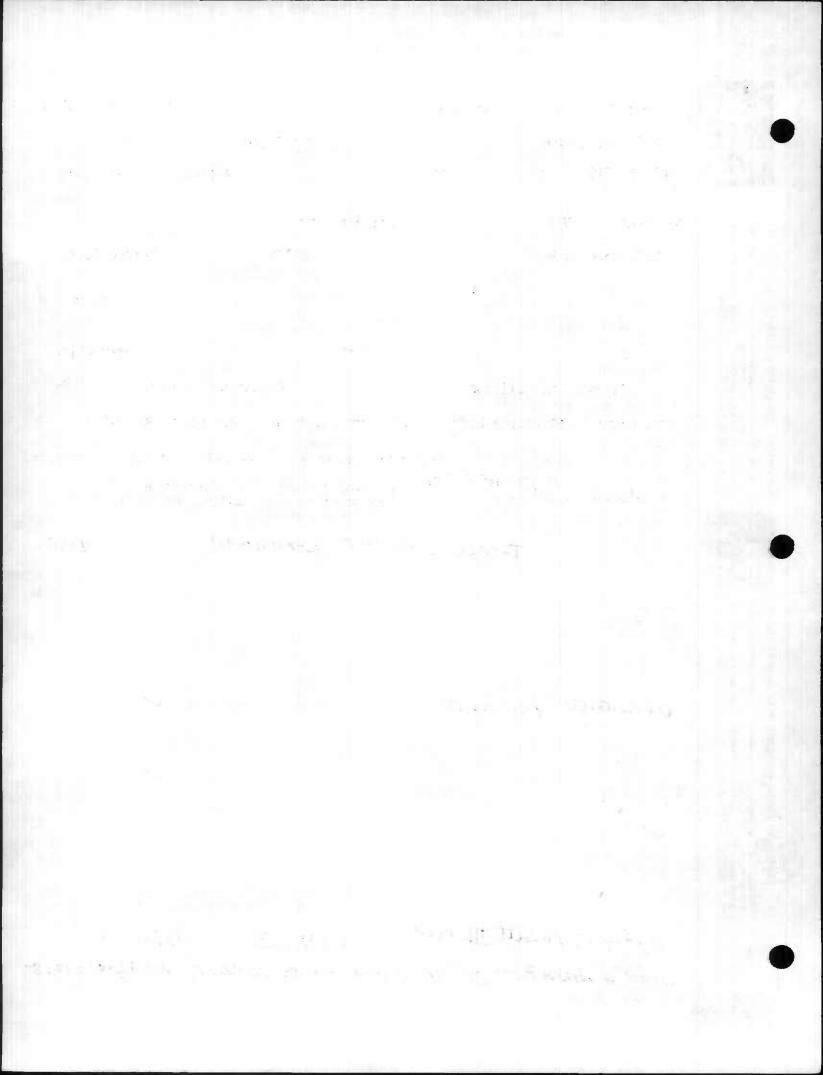
State Registrar

31. Date filed (Month, Day, Yaar)

29b. Signature and title of certifier



29c. License number 014623



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Francis J. Scott 1998 725 Au 09 4b. City, Town, or Location of Peath 4a Facility Name (If not Institution, giva street and number) 4c. County of De North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (Stata or Foreign Country) Months 1 **X**M 2□ F Days Hours 195 20 3745 Yrs. 71 May 29, 1927 Pennsylvania Usual Realdence of Decedent 10b. County 10c. City, Town or Location 10d. Inaide City Limits 1 ☐ Yes 2 ☐ No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21060 304 Marie Avenue U.S. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Biack, Whita, etc. 11. Marital Status 1 ∀Yes 2 □ No If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Dacedant's Education (Specify only highast grada complated) Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 18b. Kind of Business/Industry Elemantary/Secondary (0-12) Coilege (1-4or 5+) Chemical Foreman W. R. Grace Co. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Garahan Walter Scott 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 304 Marie Avenue Paul Scott / son Glen Burnie, Maryland 21060 20b. Place of Disposition (Neme of cametery, cramatory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 XBuriai 2 Cremation 3 Removal from State Glen Haven Memorial Park 7/13/98 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 promisouste nna Part1. Entar tha disaa ahock, or haart failura. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no cause on each lina. Onset and Death Immediate Causa (Final disease or condition resulting in death) neumo ystis Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events rasulting in death) Last Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2D No 1 ☐ Yes 20 No 25. Was casa rafarred to medical examiner? 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 8 Othar (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Panding Investigation 1 ☐ Yes 2 ☐ No 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

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Physician

/Medical

Examiner

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"natural", or items 23a or 28a-f show edical Examiner must be notified at

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29b. Signative and title of certifier

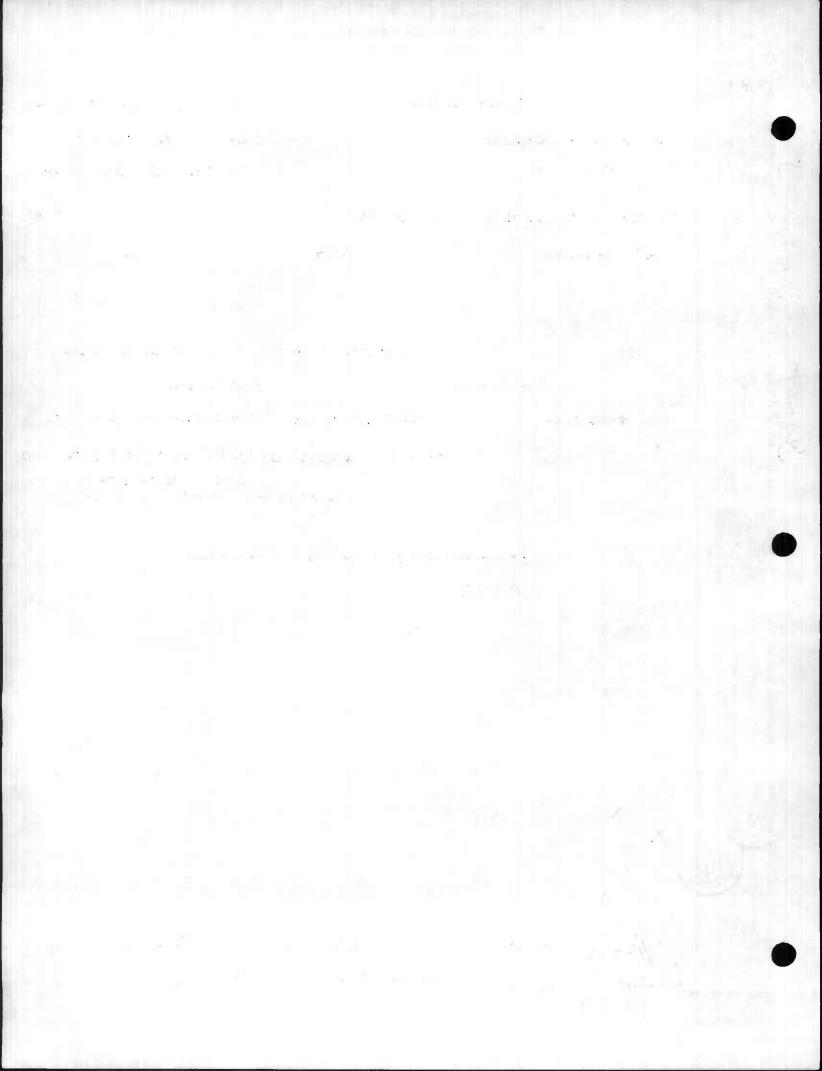
29a. Certifier

State Registrar Certifying Physician: To the best of my knowledga, daath occurred at the time, date and piaca, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and manner statad. 29c. Licansa number 29d. Data signed (Month, Dev. Year)

nd addrass of person who complated causa of death (Item 23a) (Type, Print)

North 11tani win.



Please Type or Print in Black indelible lnk. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#24a per Phy G761 7/14/98 EW Reg. No. 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Date of Deeth Month FRANK SHUTTY JULY 1, 1998 1 PM 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Mariner Health Center Anne Arundel 6. Sex 1X M 2 ☐ F If Under 1 Year Birthplaca (Stata or Foraign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Days Yrs 168-03-0329 87 August 31, 1910 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1445 Gordon Drive U. S. A. 21061 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 3 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 8 Miner Coal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Shutty Rosalia Reyczak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Shutty (Son) 341 Tulip Oak Ct. Linthicum, Maryland 21090 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Bernards 7/4/98 Hastings, Pennsylvania 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Singleton Funeral Singleton Funeral Home PA 1 Second Avenue S.W. Glen Burnie, Maryland 21061 Rael ions the dused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, ause of mach line. 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Approximate Interval Batween Onset and Daath Immediate Cause (Finei disaase or condition resulting in deeth) Metastatic mouth Carcinoma Due to (or as a consequence of): Due to (or as a consequence of) Sequentially list conditions.

Physician /Medical **Examiner**

the attending physician and hed for use es the buriel-transit the death certificate be executed

After this certificate has

Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this cartifical letely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

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Director

from 27 is marked other than "naturel", or items 23a or 28a-f show other treumstic event, the Medical Exemples must be notified at

permit. Pages 1 and 2 should be filled within 72 hours effer death v Department of Health and Mentel Hygiene. Important: if frem 27 is marked other than "natura" once.

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Examin Physician/Medical þ Completed Be Certification: To

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V V				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth? 1 Yes 2 No
25. Wes case referred to medical		-	28. Place of Deat	h (Check only one)	
axeminer? 1 ☐ Yes 2 SoNo	Hospital: 1 Inpatient 2 ER/Outpatient	ma 5□ Rasidence 8 □Oth	ner (Specify)		
27. Menner of Deeth 1 \$\infty\$Dlature1 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Dey Year) 28b. Time of Injury		injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurre	red
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, ferm, street, building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Steta)			
	ysician: To the best of my knowledge, deeth oc niner: On the basis of examinetion end/or invest end manner stated.				

29c. License number

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29d. Data signed (Month, Dey, Year)

Road #106 Oclenton

State Registrar

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Medical

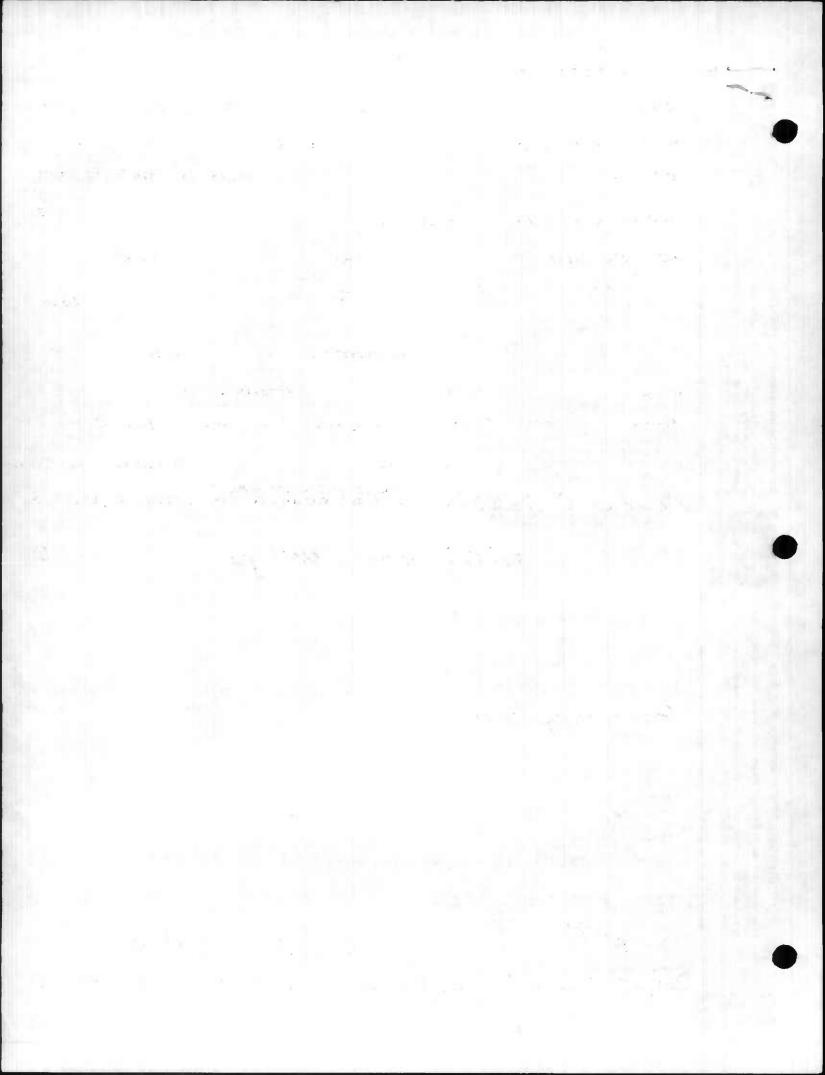
29b. Signature and title of c

ied (Month, Dey,

MD

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

WAVE



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) Month Day Vaar **Physician** Hilda Somerville July 9 1998 12:00 A.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner 5409 Park Road Baltimore Anne Arundel if Undar 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 M 2 1 F Yrs. 220 03 0547 81 Nov. 25, 1916 Virginia Director Usual Rasidanca of Decedent death with the Marylend 10c. City, Town or Location 10d. Insida City Limits r 28a-f ahow inotified at 10a. State 10b. County 1 ☐ Yes 20 No Maryland Baltimore Directo Anne Arundel 10f. Zip Coda 10g, Citizan of What Country? 10e. Street and Number an "natural", or Items 23s or Medical Examiner must be r U.S. 5409 Park Road 21225 Funeral 14. Race - Amarican Indian, 12. Was Dacedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any Injury or other traumatic event, the Modesi Examina 1 ☐ Yas 2 ☑ No if Yas, Giva Year or Datas: 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: Specify: White à 3€ Widowed 4 Divorcad Completed 16a Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade complated) (Giva kind of work dona during most of working lifa. DO NOT use retired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Own home 6th 18 Mothar's Nama (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be Nina Furniss Harold Knight 19b. Meiling Addrass (Straaf end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Ruth Jordan / daughter 5409 Park Road Baltimore, Maryland 21225 20a, Mathod of Disposition 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Stata Johnson United Methodist 1 Burial 2 □ Cramation 3 □ Removal from Stata 7/12/98 Johnsontown, Virginia 4 ☐ Donetion 5 ☐ Othar (Specify) Church Cemetery 22. Name and Addrass of Facility 21. Signatura of Funaral Sarvice Liganum Gonce Funeral Home P.A. 4001 Ritchie Highway Baltim flications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, me cause on each line. Baltimore, Md. 21225 ma 234. Part1. Enter the disaasa, or shock, or heert feilure. Li Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition rasulting in deeth) /Medical DEMENTIA YRS ALZHEIMERS **Examiner** Due to (or as a consequence of): Physician/Medical Examiner The lew requires that the death certificete be executed physician end s tha buriel-transit Sequantially list conditions, if any, laading to immediate causa. Entar Undarlying Causa (Disease or Injury Due to (or as a consequence of): P.O. Box 68760. that initiated events Dua to (or as a consequanca of): resulting in death) Last 98 attending USB 23b. Did tobacco usa contribute to the cause of death? by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed b ivision of Vital Records. à 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? been si Completed has page 1 Yes 20 No 1 Yes 2 No certificate Physician: Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) P 28b. Tima of 28d. Dascribe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death Certification: 1 Matural 5 Panding Invastigation 1 Tyes 2 No 2 Accidant 6 Could not be datarminad 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida 24 hours Hospital 1 Carlifying Physician: To the best of my knowledga, daath occurred et the tima, data and place, and due to tha cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and mannar stated. 29a, Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. Licansa number 29b. Signature and title of certifier 117753 M.D. Lauranus 30. Name end eddress of person who completed causa of deeth (Item 23e) (Type, Print) 710 CHURCH ST. BALTIMORE, MD 21225 K'S DHARMASENA, M.D. 32. Registrar's Signature 31. Deta filed (Month. Day, Year)

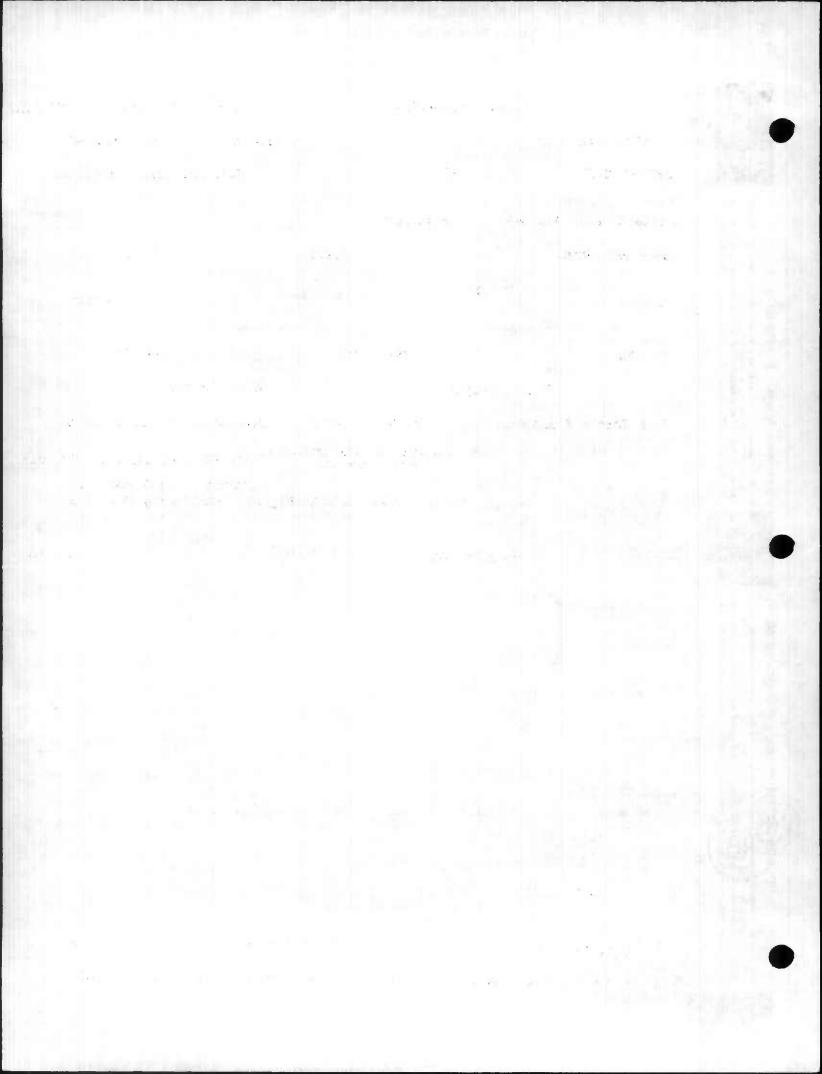
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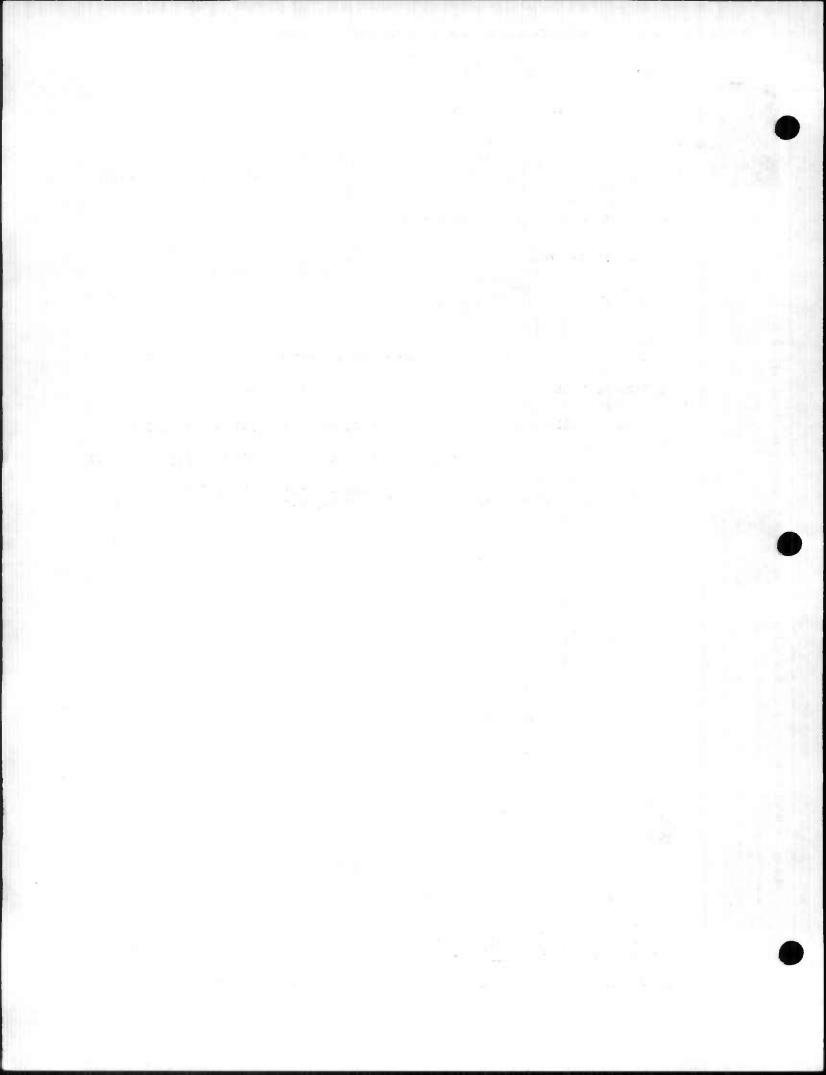
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Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month JEANETTE SAPPERSTEIN 1998 12:30pm JULY 4a Facility Name (If not institution, give street and number) MANOR CARE OF ROLAND PARK 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE N/A If Under 24 Hrs. If Under 1 Year 8. Date of Birth SEPT Day 242,1913 MARYLAND 5. Social Security Number 213–46–2329 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Days Hours 84 Months 1 □ M 2 🖫 F Yrs Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND N/A BALTIMORE 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 3615 FORDS LANE, APT. 705 21215 USA 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME **HOMEMAKER** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) ROSENSTEIN LEVIN HARRY FANNIE 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 124 ROCKRIMMON ROAD REISTERSTOWN, MD 21136 MR. GARY SAPPERSTEIN (SON) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete cemetery, crematory or other place) BETH YEHUDA ANSHE KURLAND 7-12-1998 BALTIMORE, MD 4 Donation 5 Other (Specify 22. Name and Address of Eacility LEVINSON & BROS, INC. 21. Signature of Funerel Service Li 8900 REISTERSTOWN ROAD BALT 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, of heart feiture. List only one cause on each line. 8900 REISTERSTOWN ROAD BALTIMORE, MD 21208 Approximete Intervet Between Onset and Death RESPIRATORY FAILURE 1 DAY Immediete Cause (Final disease or condition resulting in death) 5 9A4S HEPADIC COMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest END STAGE LIVER FAILURE Due to (or as e consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en eutopsy CARDIAC ARRHYTHMIAS 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26 Block of Doeth (Check only and)

Physician /Medical Examiner

Box 68760

P.O.

Division of Vital

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r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: If them 27 is marked other than "natural", or item any injury or other traumatic event, the Mental and page.

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Examiner uneral Certification: al or Attenders.

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a □ Guloido 6 □ Could not b	Α	-			and I amelian (Orange and March and an David D						

determined 4 - Homicide

Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier Reigh

29c. License number D-22609 29d. Date signed (Month, Day, Year) JULY-11-1998

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

7445 FURNACE BRANCH Rd 61EN BURNIE Hd 21060 FUBEN REIDER M.D.

Registrar

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31. Dete filed (Month, Day, Yeer)

29a, Certifier

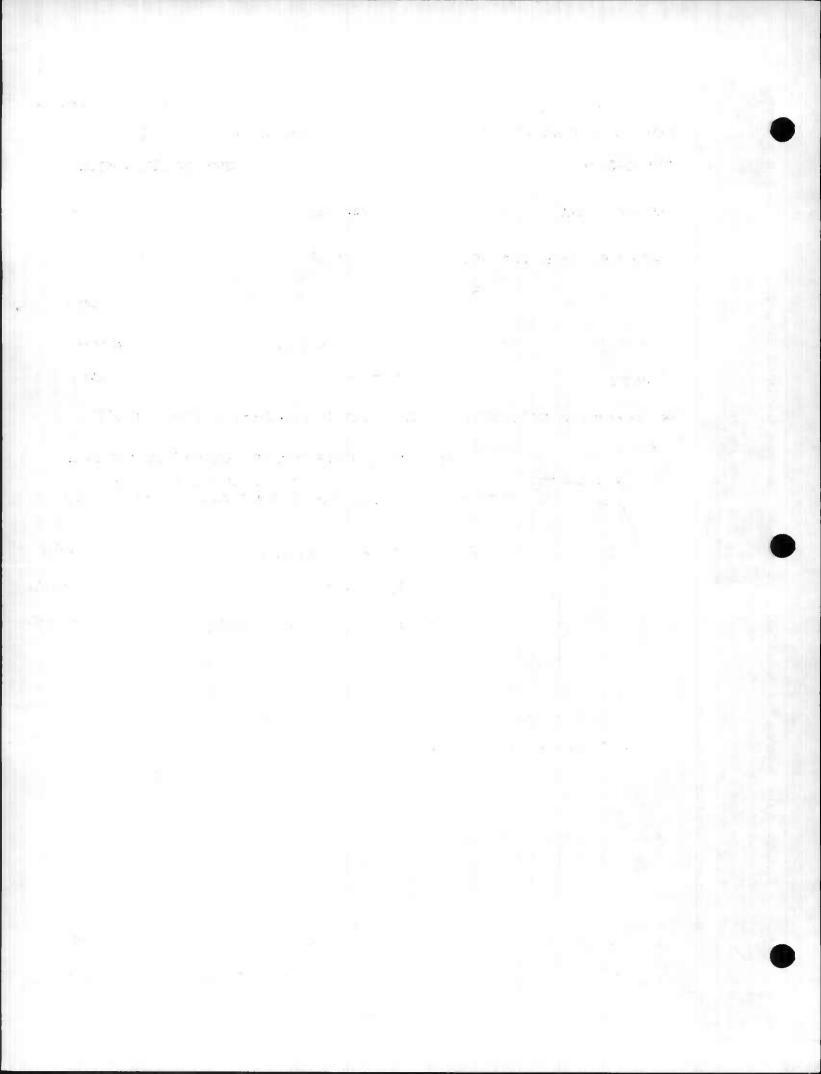
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JUL 141998

32. Registrar's Signature

Bulia Davidson-Randalle

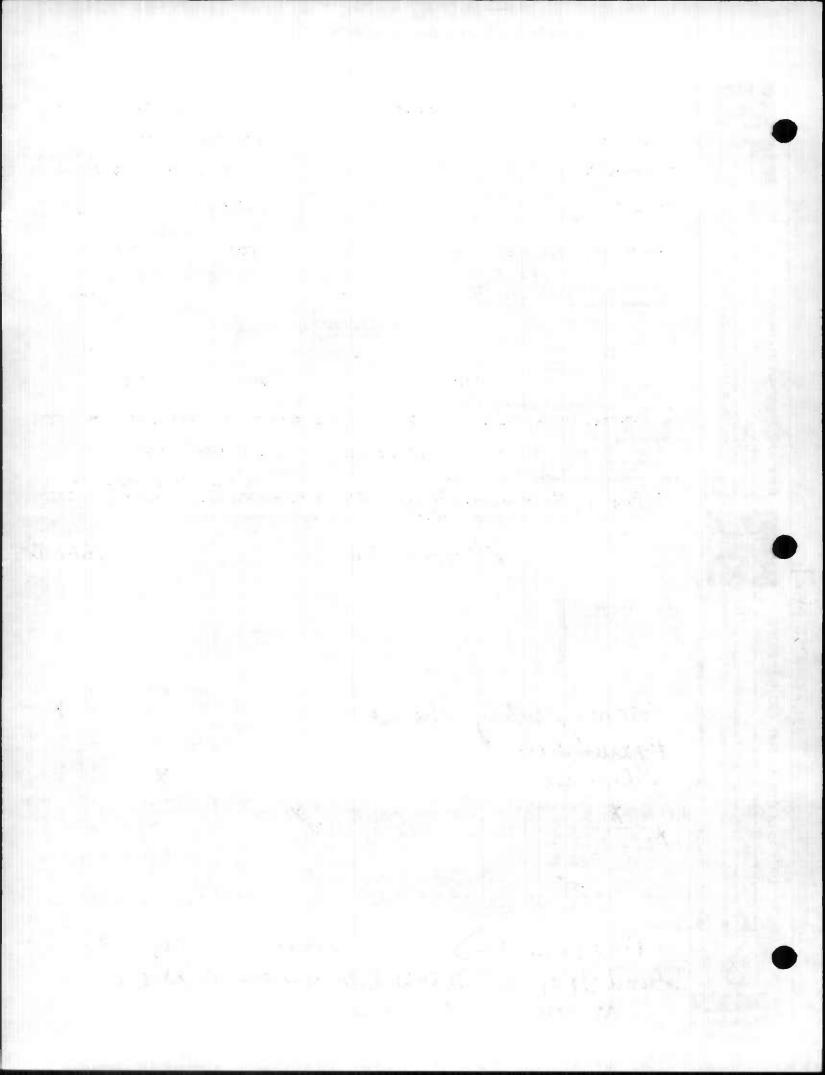
To the Hospital o within 24 hours of To the Funeral Di completely filled in



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death The (First, Middle, Last) 2. Date of Deeth Month Day Year

				ic or maryiar		tificate o			Reg. No.	21	553
	Physiciar	Decedent's Name (First,	Middle, Last)					2. Date of Dee	eth Day	Year	3. Time of Death
	/Medica	SA	RA		SUFFEL			JULY 1	0, 1998		7pm
	Examine	4a Facility Name (If not ins	stitution, give street e	nd number)				ALTIMORE	N/A		
	Funeral Director	5. Social Security Number 144–12–8070 Usual Residence of Deced		XF 7. Age (In yrs. 86	lest birthday) Yrs.	If Under 1 Ye Months Day			, Year) , 1912	9. Birthplac Country NEW J	e (Stete or Foreign ERSEY
	Maryland of show	10a State MARYLAND 10b. C	N/A	10c. Cit	ty, Town or Loo	cation	В	ALTIMORE			Inside City Limits 1 Yes 2 No
	filer death with the Mar r flerms 23s or 28s-f si precedulation	10e. Street end Number 2500 W. BEL	VEDERE AV	E. APT.	410	10f. Zip Cod		1215	10g. Citizen of \	What Country	?
020	alf. o		Arm 1 ☐	s Decedent Ever in U led Forces? Yes 2 X No es, Give ir or Dates:		Vas Decedent of Yes, specify C	of Hispanic Orlgln? (Suben, Mexican, Puer lo Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	ca - American ck, White, etc. v: WH	
imore, Maryland 2	ges 1 and 2 should be filed within 72 hours on 10f Health and Mental Hygiene. If flem 27 is marked other than "natural", coor other traumatic event, the Medical Exert	15. De (Specify only) Elementary/Secondary (12	cedent's Education highest grede comp 0-12) Col	leted) lege (1-4or 5+)	16a. Deced (Give I life. L		cupation ne during most of wo ired)	rking	16b. Kind of B	usiness/Indus	
	Mental Hygi Mental Hygi arked other etic event, I	17. Father's Name (First, N	fiddle, Last)	BECKER			18. Mother's Na	me (First, Middle, ANNIE	Meiden Sumen		
	0.000	19a. Informant's Name/Re MR. BERNARI		66.			eet end Number or R				D 21208
	permit. Peges 1 and Department of Health Important: if Item 27 any Injury or other to once.	20a. Method of Disposition 1 Burial 2 Crem 4 Donellon 5 Of	ation 3 Remova	from State	Place of Dispose	sition (Name of allory or other JACOB	oleca) 7	Date -12-1998	20c. Location -		*
Balti	permit. Peg Department Important: It any injury o	21. Signature of Funeral S	ervica Licendee	O man	20 0000		dress of Facility S	OL LEVIN OWN ROAD			
The second	Physician /Medical Examiner	23a. Part1. Enter the disershock, or heart tallure Immediate Cause (Final disease or condition resulting in death)	ase, or complications b. List only one caus	Blody	or as a conseq	Pance	dying, such as cardia	c or respiratory as	rest,	In	pproximate iterval Between inset and Death
Box 68760,	requires that the death certificate be executed seen signed by the ettending physician and hould be deteched for use as the burish-trainsit	Cause (Disease or injury that initiated events resulting in death) Last	c		or as a consequ						
P.O. B	that the death cert ed by the ettendin deteched for use	Part II. Other significant co	onditions contributin	g to death but not res	sulting In the un	deriying cause	given in Part I.	23b. Did tobacco usa contribute to the cause			11
	w requires that been signed the should be determined by Diesermine the bear of	Hand	of an	ary c	wew	19		24a. Was	an autopsy	availa	autopsy findings
Records,	2 s 2	Dene	ntis						res 2 No	comp of dea	eletion of cause ath?
Vital	clan: The last rector, page		nedical				26. Place of De	ath (Check only o	one)		
10	F 10 F	1 Yes 2 No	Hospital	1 ☐ Inpatient 2 ☐	ER/Outpatien	3LI DOA		Home 5 Resid			
Division of	After fune	27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6	Pending Investigation	Date of Injury (Month, Dey Year)	28b. Time of Injury	M 1	njuryat Nork? □ Yes 2 □ No		now Injury occur		
DIV	To the Hospital or Attentivity of Posts and Posts To the Funeral Directors completely filled in by the Manifest Contributes		determined 28e.	Place of Injury - At h building, etc. (Special		eet, tactory, offi	ce	City or Tou	Street end Numi vn, Stete)	Der or Hurar H	oute Number,
	Within 24 hours completely filled	The State of the S	dical Examinar: On an	To the best of my kno the basis of examine d manner stated.		estigation, in m	y opinion, death occ	urred at the time,	date and placa,	and due to th	ne cause(s)
	Total S	296. Signature and fittle of	Jane 1	and		29c. Llc	44817		July	11 - 1998	y, Year)
	2	30. Name and address of	Ray a	d cause of death (Iter	m 23a) (Type, I 34 W	Belie	dere a	ie Ra	Ulleo	se	
ľ	State	31. Date filed (Month Cay,	1 1000	32. Registrar's Sign	atura 70	1.00					

DHMH 16 Rev 6/95

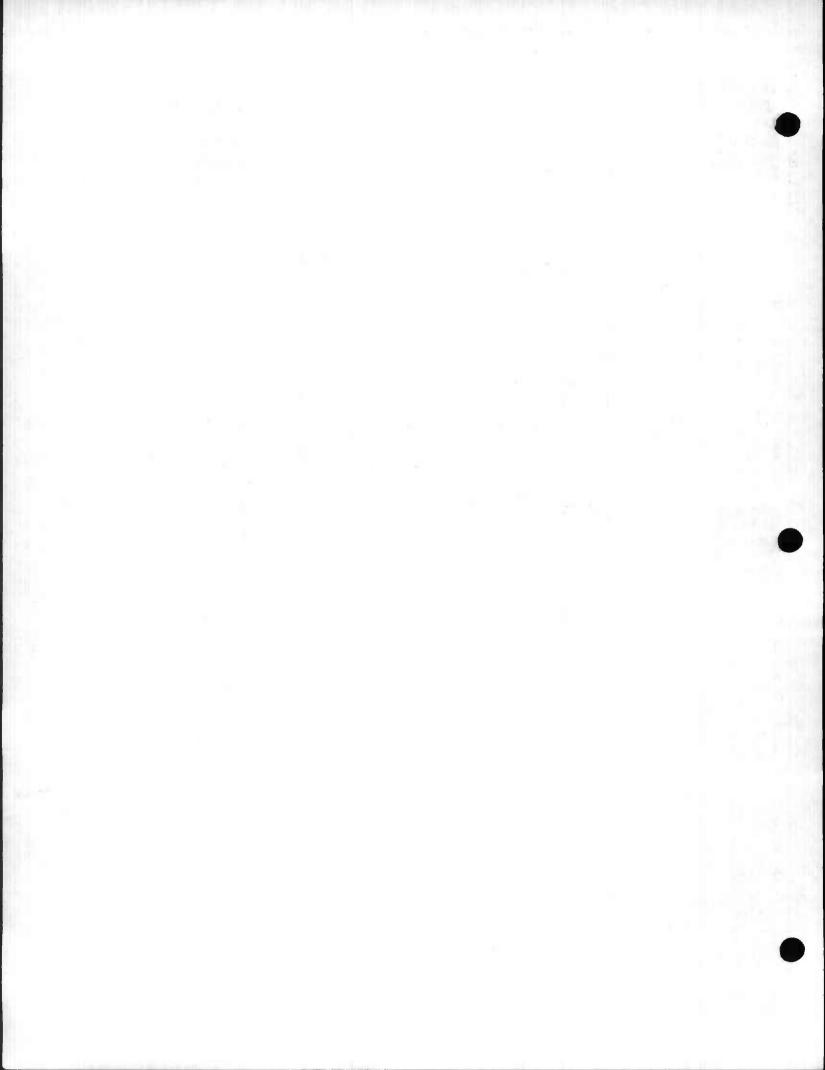


			1. Decedent's Nama (First, Middle, Las	it)		2. Data of De		3. Tima of Death			
	Physic /Medi		William	Smith	SR.	July	Day Year 10, 1998	7:32 A			
	Exami		4a. Facility Name (If not institution, give			or Location of Death					
1			MERCY - STEL	IA MARIS	Baltu	nore	NA				
	Funeral		5. Social Security Number 6. S	ex, 7. Aga (In yrs. last birth	nday) If Under 1 Year If Under 24 h	rs. 8. Date of Bir	th 9. Birth	place (State or Foreign			
1	Director		212-58-4340 1	XM 2□F 46 Y	rs. Months Days Hours M	lin. (Month, De	651	intry) MD			
	PL .		Usual Residence of Decedent								
	show	_	10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits			
	M Page	Sct	MD NA	JA!	timoee			1⊠Yas 2□No			
	\$ 0 E	Di-	10e. Street and Number		10f. Zip Coda		10g. Citizan of What Cou	intry?			
	23a	<u>ra</u>	3301 Koycs	E AUE	21215		U.S.A				
	tema tema	Funeral Director	11. Marital Status	 Was Decedent Ever in U,S. Armed Forcas? 	 Was Decedent of Hispanic Origin? If Yas, specify Cuban, Mexican, Pu 	(Specify Yas or No arto Rican, atc.)	- 14. Raca - Amer Black, White				
20	72 hours efter death with the Maryland natural', or items 23a or 28s-f show diest Examinet must be notified at	by F	1)Naver Married 2 Married	1 ☐ Yes 2 → No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:		Specify: 1	1. 1.			
5-0020	ural'	D D	3 Widowed 4 Divorcad	Yaar or Datas:			10	MACK			
15	"nat	Completed	15. Decedent's Ed (Specify only highast gra	de completed) (Decedent's Usual Occupation 'Giva kind of work done during most of t life. DO NOT use retired)	working	16b. Kind of Business/Ir	idustry			
2121	within ene. then "	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)	01 1		Do ato				
	filed with Hygiene. ther ther	Ö	12+# GRADE 17. Fether's Name (First, Middle, Last)	UIA	Flumber 18 Mother's N	lame (First, Middle,	Maiden Sumama)				
an	ould be i Mentai I arked of atic eve	Be C	C-500 5	. 2).	01-	11.1	maios: ournamo,				
2	should nd Men marke umatic	2	19e. Informent's Name/Relationship (7	m m n	Mailing Address (Street and Number of	HICKS	ns Cibras Taum Stata 7	in Codo)			
Maryland	d 2 sho th end 7 is me traum		11	:11	Meiling Address (Street and Number or	O - V	DI	210			
e,	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		VANESSA D 20a. Method of Disposition	20b. Place of	Disposition (Name of	Date	20c. Location - City or T	170 21207			
100	Peges nent of nt: If ite iry or o		1 Burial 2 ☐ Cremation 3 ☐	Removal from State	, crematory or other place)		0 1 11 +				
Baltimore,	permit. Pe Depertmen Important: any Injury once.		4 Donation 5 Other (Specify	11109	MEMORIAL PARK			OWN, MD			
Ba	permit. Depentriments Imports any injugant		21. Signature of Funeral Servica Lican.	388	22. Name and Address of Facility -	FUNCER	+ Home	WESTIN			
_			Dlades	Grano	4300 WABAST	AUE I	Balto MD	21215			
			23a. Part1. Enter the disaase, or Jomp shock, or heart feilure. List only	dications that caused the death. Do no ona ceuse on each line.	ot entar the mode of dying, such as card	liac or respiratory a	rrest,	Approximate Interval Between Onset and Death			
	Physician		Immediate Ceuse (Final								
	/Medical Examiner		disease or condition resulting in death) Non-Hodgkins Lymphoria Due to (or es e consequenca of):								
	LXUIIIII	L.	resulting in death)	Due to (or es e co	onsequenca of):						
	be sit	Examiner		b							
	executed n end lat-transit	хап	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):						
68760,	E LE		Cause (Disease or Injury	C							
387	phys the	dic	thet initiated events resulting in death) Last	Due to (or as a co	nsequenca of):		1				
×	hath certificete be executed ethereding physician end for use es the bunal-transit	clan/Medical		d							
Вох	etten for u	cian									
P.O.	The law requires thet the de ate hes been signed by the e page 2 should be deteched I	Physic	Part II. Other algnificant conditions co	ntributing to death but not resulting in t	the underlying cause given in Pert I.	23b. Did	tobacco use contribute	to the cause of death?			
	ad by dete	4	CLL			1 🗆	Yes 2, KNo 3 □ Pro	obably 4 Unknown			
Records,	sign d be	d by				Ode Wee	24b W	Vere sutoney findings			
Ö	v require been si should	Completed				perio	an autopsy 24b. V rmad? a	Vere autopsy findings vailable prior to ompletion of cause			
36	hes law	du					o'	f death?			
E	The cate	ပ္ပ				10	Yas 200 1	☐ Yas 2☐ No			
Ziti	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	14		Death (Check only o	me) Stella Ma	ris at Merc			
of Vital	Physic this or ral dir	မ	1 193 2 2 7 140	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp		7	denca 6 Dother (Spec	(h) Hospice			
L C	After funer	on:	27. Menner of Death 1.≅Natural 5 □ Pending		ury Work?	28d. Describe I	now Injury occurred				
Division	Attending or death. sctor: After by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be		M 1 Yes 2 No						
Ξ	fter d irect	E	4 Homicide determined	28e. Placa of Injury - At home, fame building, etc. (Specify)	n, street, fectory, offica	28f. Location (City or To	Street and Number or Rui vn, State)	al Route Number,			
	To the Hospital or Attending Physician: The Is within 24 hours effected ash. To the Funeral Director: After this certificate he completely filled in by the funeral director, page										
	Hosp 14 ho Fune tely f	edical	(Check only 2 Medical Exam	Iner: On the basis of examination and/	death occurred at the time, dete end ple or Invastigation, in my opinion, death oc	ece, end due to the ecurred at the time,	ceuse(s) end manner es dete and piece, end due	stated. to the cause(s)			
	the mble	Med	one)	and menner steted.	20a Haansa numbar		20d Date signed (Month	Day Year			
	5 ¥ 5 8		29b. Signature and title of certifiar	maron	29c. Licansa number		29d. Data signed (Month				
	ha		7 0 "	samo	040480		Inly 10,	1975			
	17		30. Name and eddress of person who o	-	ype, Print) 7672 2 32/90	elair k	1				
			FERNANDO V.	FERRO, MD		210	236				
	Sta	- "	31. Date filed (Month, Day, Year)	998 32. Registra Signatura	10. 1.00°						
	Registr	ar	201141	James During	John-Marlandor						
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Certificate of Death

21554



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedant's Nama (First Middle Last) 2. Date of Death 3. Time of Deeth Am **Physician** 4:40 A. 10 1998 Dorothy Sergotick July /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Timonium, Maris Stella Md. Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (State or Foreign Country) 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Montha Days 1□ M 2☑ F Yrs. 70 22 Md. 212-24-8691 Oct Director Usual Rasidance of Decedant the Manyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Show item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Example must be notified at 1 Yas 2 □ No Directo Md NA Baltimore, Md. 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? with California permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a and Injury or other traumatic event, the Medical Examples 200. 30321/2 Avenue 21234 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian. Black, White, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White leted 18a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decadent's Education (Spacify only highest grade completed) Compl Elamantary/Secondary (0-12) Collega (1-4or 5+) 10th NA Homemaker Home 18 Mothar's Nama (First Middle Maiden Surgema) 17. Fethar's Neme (First, Middla, Last) Be Charles Eckles Dorothy Gross 2 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Ignatius Sergotick/husband 3032½ California Ave., Baltimore Md 21234 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 7/13 4 ☐ Donation 5 ☐ Othar (Specify) Parkwood Cemetery Baltimore 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvica Licansee Hartley Miller Funeral Home, CHTD. 23a. Pert1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final Cancer disaasa or condition rasulting in daath) Examiner Examiner Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that Initiated evants resulting in death) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 88 use a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the a signed by t 1 Yes 2 No 3 Probably 4 Unknown Mellitus g 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy Completed page 2 s 2 No 1 Yas 2 No 1 Yas certificate or Attending Physician: funeral director 25. Was casa raferrad to medical Be 26. Pleca of Death (Check only ona) Other: 4 Norsing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Deta of Injury (Month, Day Year) 28c. injury at Work? Certification: 27. Menner of Death 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No 24 hours after death. Funeral Director: Al invastigation 2 Accident 6 Could not be datermined 3 Suicida Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicide Hospital 1 Certifying Physician: To the bast of my knowledge, death over red at the time, data and place, and due to the cause(s) and manner as stated. 29a. Cartifiar Medical within 24 hor To the Fune completaly fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and menner steted. To the 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier-30. Name end eddress of person who comple cause of deeth (Item 23a) (Type, Print) BALTO PO 2318 TOPPA FD Michan 21234 31. Data filad (Month, Day, Year) 32. Ragistrar's Signature State Julia Davidson 4 1998 Registrar

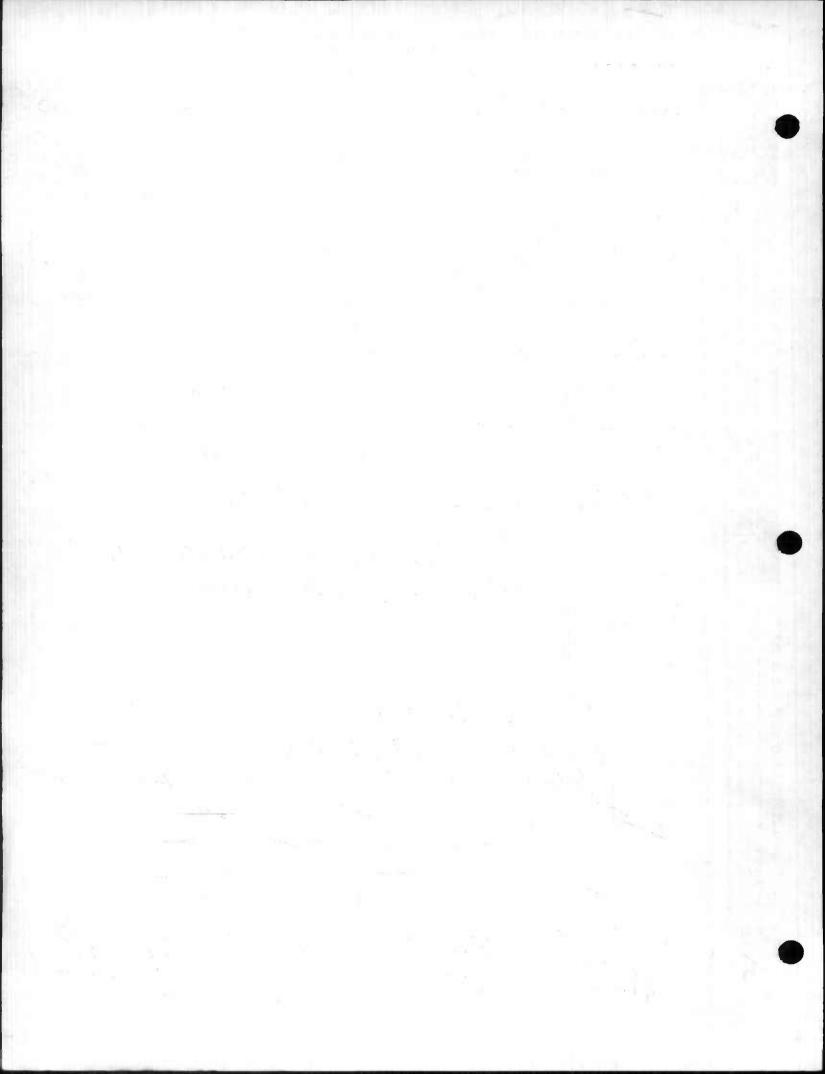
The Port of a Comment of the Section THE TANK THE PARTY SHOWS IN ent on a recommendation of the section of

State of Maryland / Department of Health and Mental Hygiene Amend: #26 Per MD Film G761 7-14-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ietta 06 2010 30 /Medicai 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Inai If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 224-26-9898 N.C Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notitied at NA Baltimore 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 212/5 Avenue *natural", or items 23a 2915 5. man Funerai 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Jack 1 ☐ Yes 2 No py 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within:
Department of Heelth end Mental Hygiens important: If hem 27 Is marked other than any Injury or other traumatic rivate Elementary/Secondery (0-12) College (1-4or 5+) NH 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Julius Naws ula 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/239 19a. Informant's Name/Relationship (Type, Print) Thomas-Son imbod Arenue Apt 5805 110w ton 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility la wabash ane 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death such as cardiac or respiratory arrest, **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner bunial-transit and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in death) Lest Box 68760, attending physician Physician/Medical the Due to (or as a consequence of): 950 detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by the 3 Probably 4 Unknown 1 Yes 2 No Completed by 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was an eutopsy performed? page 2 s this certificate 25. Was case reterred to med examiner? the Hospital or Attending Physician: Thin 24 hours after death.

the Funeral Director: After this certifica mpletaly filled in by the funeral director, p 26. Place of Death (Check only one) Be Other: 4 Nursing Home • Posidence 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: 1 Natural 5 Pending Investigation Injury 1 Yes 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the ...
within 24 hours.
To the Funeral Directors.
Ataly filled in 'Ataly filled i 4 Homicide tidecritifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end 29d. Dete signed (Month, Dey, Year) 30. Name and ad son who completed cause of deeth (Item 23a) (Type, Print) 31. Date filed 32. Registrer's Signature State Julia Davidson

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Tima of Daath 1. Decedant's Nama (First, Middle, Last) Deborah Ann Thomas 6:26 am JUN 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) GIEN BURNIE ARUNDEL HOSPITAL A. A. COUNTY NORTH If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign 5. Social Sacurity Number 1 □ M 2 1 F Months Yrs. 219 62 9743 5, 1955 42 Maryland Usual Rasidanca of Dacedant 10d. Insida City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena 10e. Streef and Numbar 10f. Zip Coda 10g. Citizan of What Country? 8554 Bay Road 21122 U.S. 12. Was Dacedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Spacity Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1 ☐ Yas 2 No If Yes, Giva Yaar or Datas: 1 □ Navar Married 2 □ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 12 Divorced 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) State Ommision Elamentary/Secondary (0-12) Collaga (1-4or 5+) Marta Technology 12th Secretary / Receptionist 18. Mothar's Nama (First, Middla, Maidan Sumame) 17. Father's Nama (First, Middla, Last) Myrtle Murphy (not available) Don 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 399 Lenlow Court Apt. F Glen Burnie, Md. 21061 Theresa Mitchell / daughter 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 XCramation 3 ☐ Ramoval from State 7/13/98 Towson, Maryland Hilltop Service Corp. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licansaa 22. Nama and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 Part1. Enter the disease, or sin shock, or heart failure. projections that caused the death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximete Interval Batween Onsat end Death Immediata Causa (Final disaasa or condition rasulting in death) ARRHY THMIA MYOCARDIAL INFARCTION Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Lest Dua to (or as a consequence of) Dua to (or as a consaquance of) 23b. Dfd tobacco use contribute to the cause of deeth? Part II. Other eigniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown CIGARETTE SMOKER 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy HISTORY OF HEART DISEASE 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case raferred to medical examiner? 26. Placa of Daath (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 28a. Data of Injury (Month, Day Year) 1 Natural 5 Panding

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and placa, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated.

29c. Licanse number

D29209

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

7/9/98

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Examiner

Physician/Medical

2

Completed

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Certification:

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Director

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7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Modical Exemptor must be notified at

2 should be filed within 72 hours after death and Mentel Hyglens.
Is marked other than "naturel", or itams 23.

permit. Peges 1 and 2 st Department of Heelth and Important: If item 27 is n eny injury or other traun

Maryland 21215-0020

Baltimore.

Box 68760.

Division of Vital Records, P.O.

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State Registrar

31. Data filed (Month, Day, Year)

29b. Signatura and fitta of cartifiar

2 Accident

3 Suicida

29a. Cartifiar

4 Homicida

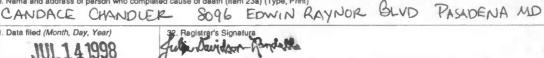
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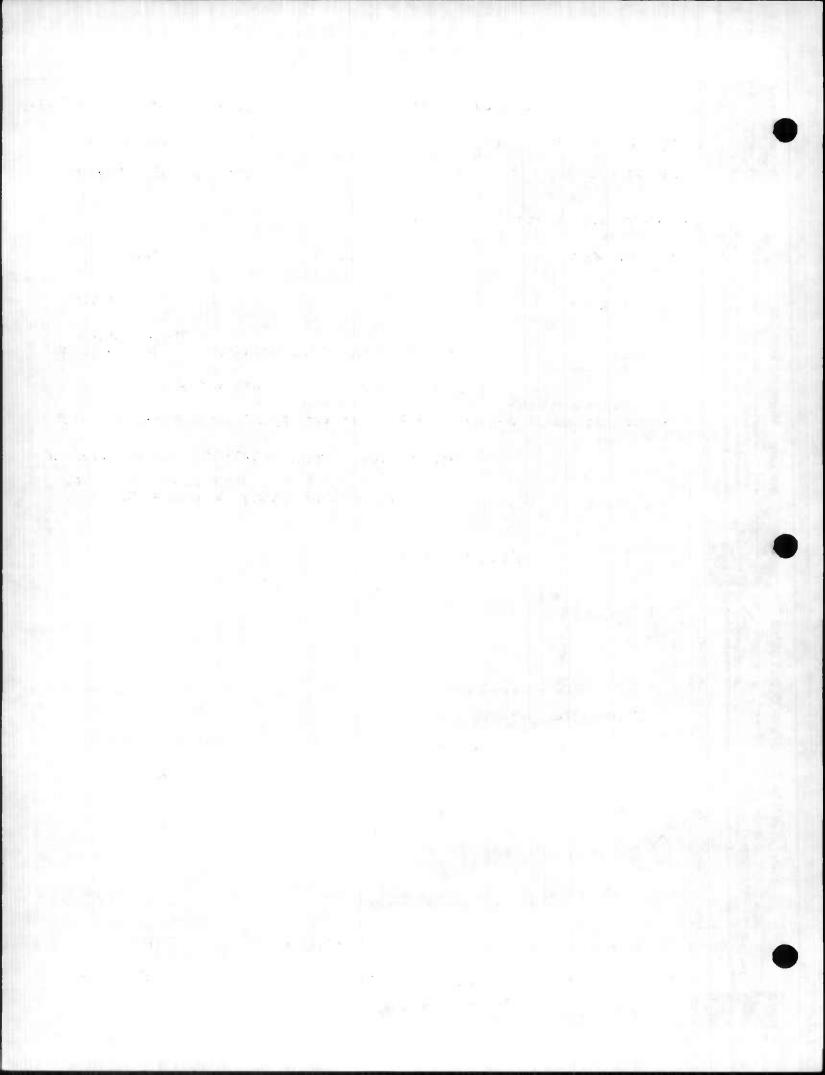
Candace Chandler MD

30. Nama and addrass of parson who complated cause of death (Itam 23a) (Type, Print)

6 Could not be determined



28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Spacify)

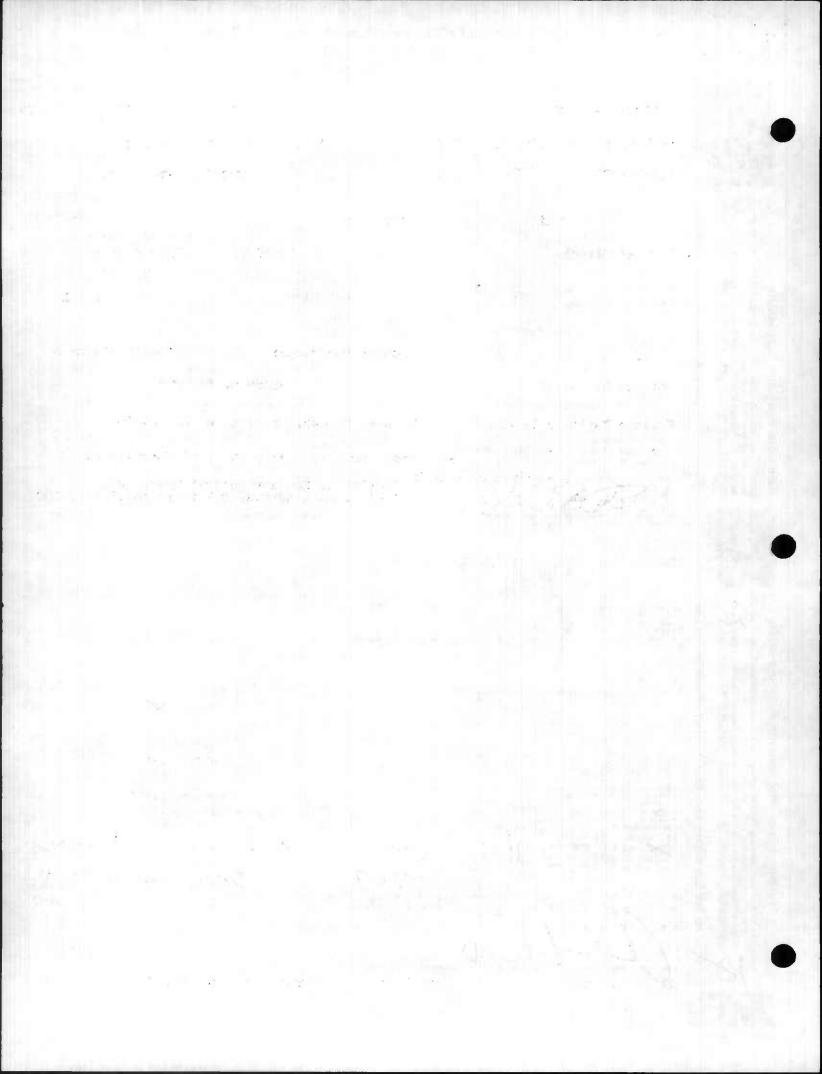


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State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	4a Facility Nama (If n			ber)			T	4b. City, To	wn, or L	ocation of Death		unty of Death	2020 119			
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	11/1	and.	The A	D			OCMI	Ε			JULY	11,	1998			
17	30. Name and addrass	s of person who	completed cause	of death (Item 23s	a) (Type,	Print)		CHEOL								
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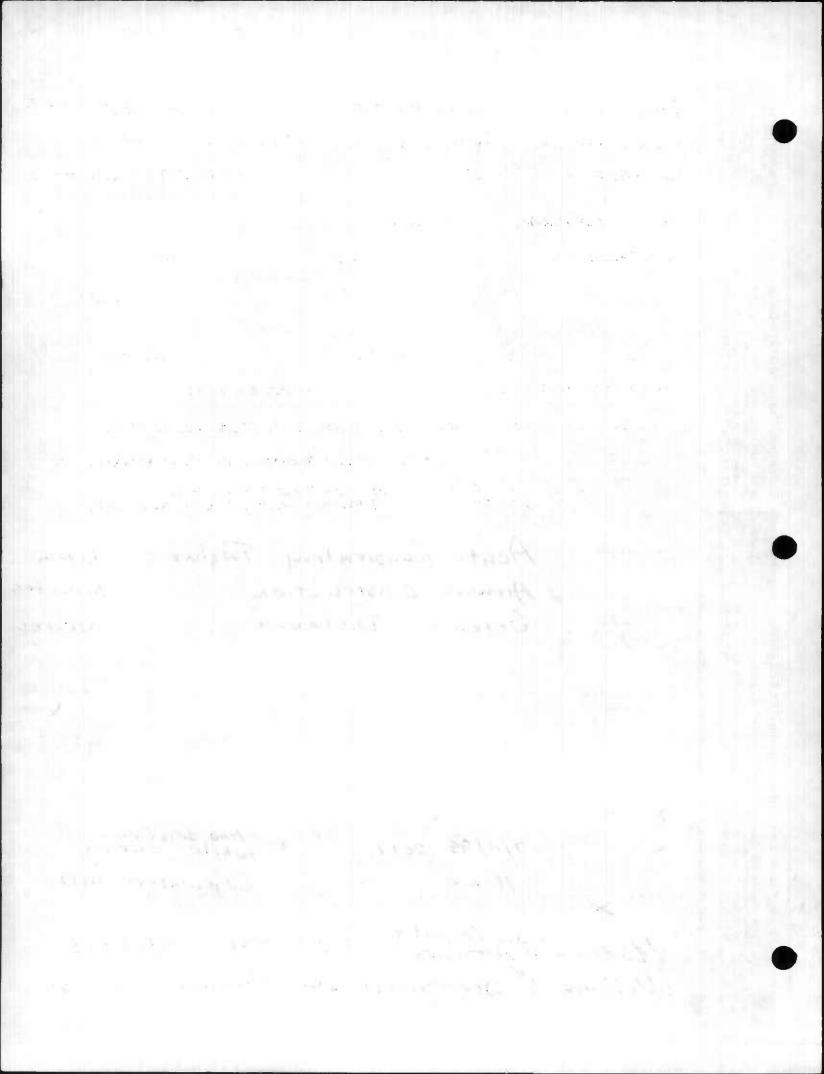


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Nama (First Middle 1 ast) Month **Physician** 2126 VANdeVANTEV 98 Ju ' /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** HUndar 24 Hrs. 8. Data of Birth (Month, Day, Year) Arundel GeN, 7. Age (In yrs. last birthday) Jif Under 1 Y TNNE Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M ME Days Hours Yrs. Director 35 216-78-7040 20,1963 Washington, DC Usual Residance of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Insida City Limits ir than "naturel", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1709 Tacoma Road 21037 Funeral USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "naturel", or its 1 Yes 2 No If Yas, Give Year or Dates: 1 Nevar Married 2 Married altimore. Maryland 21215-0020 1 Yes 2 XNo Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Ervin Bowles, Jr. Sandra Ann Sager 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other treum once. James L. VanDevanter, Jr - Husb. 1709 Tacoma Road, Edgewater, MD 21037
Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XBurial 2 Cramation 3 Ramoval from State Lakemont Memorial Garden 07/15 4 ☐ Donation 5 ☐ Othar (Specify) Davidsonville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in daath) /Medical Failure Examiner Examiner attending physician and for use as the bunal-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disaasa or Injury that Initiated events rasulting in death) Last Due to (or as a consaquance of) certificate be exec)15 ORDER Delzure Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algorificant conditione contributing to death but not resulting in the underlying causa given in Part I. detached signed by the 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. by 24b. Ware autopsy findings available prior to complation of causa of daath? Completed 24a. Was an autopsy Deen certificate has 1 Yes 2 □ M6 1 ☐ Yes 2 ☐ No Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) examiner? Hospital: Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 10 1 Inpatiant 2 PR/Outpatient 3 DOA 28d. Describe how Injury occurred /1AD SEIZUVE 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural 5 Pending Investigation death. 11/ 98 2017" 1 Yes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, State) after death Director: A 21 Accident 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 6 Could not be datarmined 3 Suicide 4 Homicida To the Hospital o within 24 hours af To the Funeral Di MD deewater 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and manner as stated.

Redical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29c. License number 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier Deputy ha and addrass of person who comp cause of death (Itam 23a) (Type, Print) Morica Jes, MD 100 31 Date filed /Month State

DHMH 16 Rav 6/95

Registrar



Piease Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 1 Per PHY Film G761 7-14-98 rja Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Wisseman, Charles CHARLES LOUIS WISSEMAN, JR. 1998 0930 AM July 12 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Maryland Medical Center Baltimore 5. Social Security Number of n/a If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Birthplaca (Stete or Foreign Country) **Funeral** 1 X M 2 □ F Months Deys Texas Yrs. Oct 2, 460-22-6471 **Director** Usuel Residence of Decedent with the Maryland 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23a or 28a-f ahor traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Cockeysville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 USA 40 Cedar Knoll Road Funeral death 12. Wes Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1943–46 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. should be filed within 72 hours after and Mental Hygiene.
marked other than "natural", or that 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Il Hygiene. University of Maryland Elementary/Secondary (0-12) College (1-4or 5+) 5+ Head of Microbiology Dept. School of Medicine 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Helen Mae Ranzau Charles Louis Wisseman, Sr. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Department of Health a Important: If them 27 la 40 Cedar Knoll Road, Cockeysville, MD Jane Wisseman/Wife 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ö Dulaney Valley Mem. Grdns.7/16/98 Timonium, Maryland 22. Name and Address of Facility Raw Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD Approximate Interval Between Onset end Deeth that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, ase, or complications that causes. List only one cause on each **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Preumonia **Examiner** Due to (or es a consequence of): Physician/Medical Examiner Squamous cell lung cancer attending physician and for use as the buhal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760, Emphysema
Duelo (or as a consequence of): ed by the a 23b. Dtd tobacco use contribute to the ceuse of deeth? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 15 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s has 1 Yes 2 No 1 Yes 2 No certificate or Attending Physician: funeral director Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Date of tnjury (Month, Dey Year) 28c. tnjury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: After 1 Watural 5 Pending investigation after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Sulcide 28e. Placa of tnjury - At home, farm, street, factory, office bullding, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. edical completely (Check only one) To the To the To the P 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

31. Date filed (Month, Day, Year) State Registrar

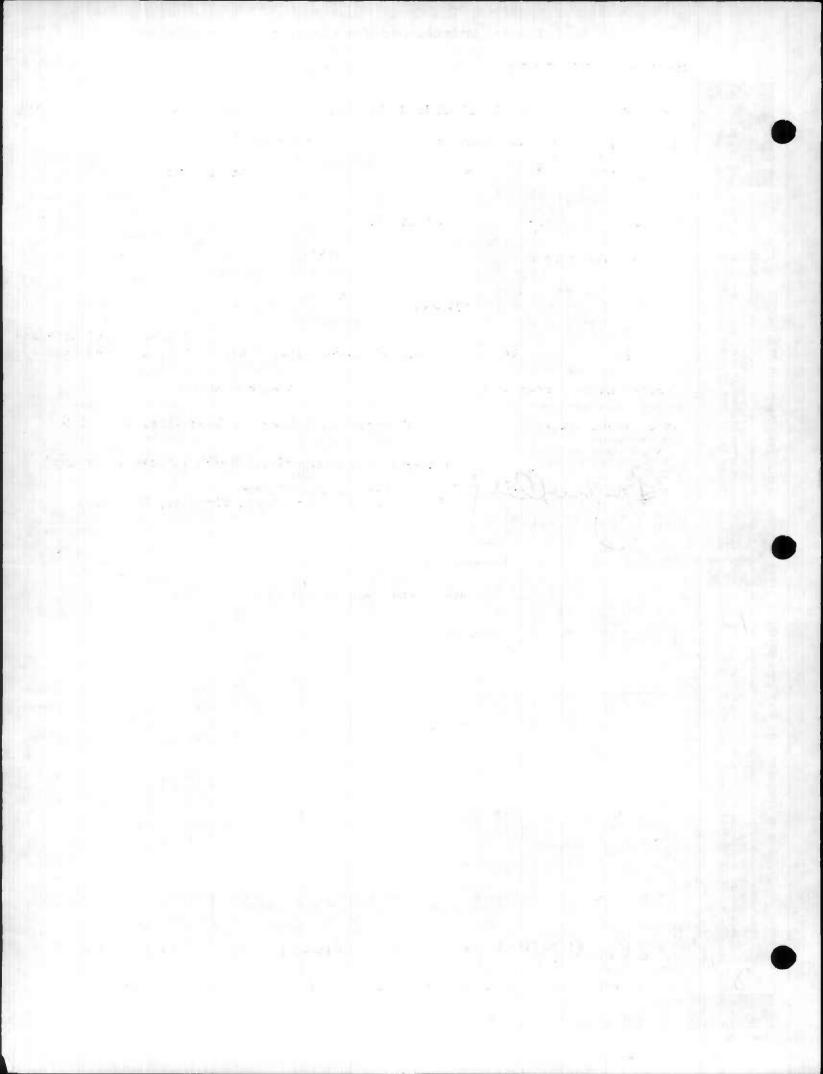
WMWS 10 S. Greene St. Bultimore, MD Elizabeth Stoller, MD 32. Registrar's Signature option. with Davidson is

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

4 1998

P10224

July 12, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death JULY **Physician** 1998 ADDIE WRIGHT 8, 6 A.M. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 868 WASHINGTON BALTIMORE BL VD If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Deys 1 ☐ M 2 🕶 F Months VIRGINIA 71 6/23/27 Director 220 12 5148 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumstic event. 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits YOYes 2 No N/A Director MARYLAND BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 868 WASHINGTON BLVD. 21230 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ Yho If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Never Merried 2 ☑ Marrled Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: AFRO. AMERICAN 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) **JOSHEA** BAILEY MARGARET BAILEY 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Pnint) MORRIS WRIGHT (HUSBAND) 868 WASHINGTON BLVD. BALTO. MD 21230 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) GARRISON FOREST CEM. 7/14/1998 OWINGSMILL MD 21. Signeture of Funeral Segrico Licenses ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 23a. Pert1. Enter the disease, or complications that couled the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner The law requires that the death certificate be executed attending physician and for use as the bunel-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Nes 2 No 3 Probably 4 Unknown cancer by 24b. Were autopsy findings eveileble prior to completion of cause of death? Vascular Disease 24a. Wes an autopsy performed? Completed certificate hes b lirector, page 2 s or Attending Physicien: Be 25. Wes case referred to medicel exeminer? 26. Place of Deeth (Check only one) Hospitei: Other: 4 Nursing Home To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) this funeral 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After 1 Neturel 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 29a. Certifier Tertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated. edicai within 24 hor To the Fune completely fi (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier 30. Name end eddress of person who completed cause of deeth (item aca

DHMH 16 Rav 6/95

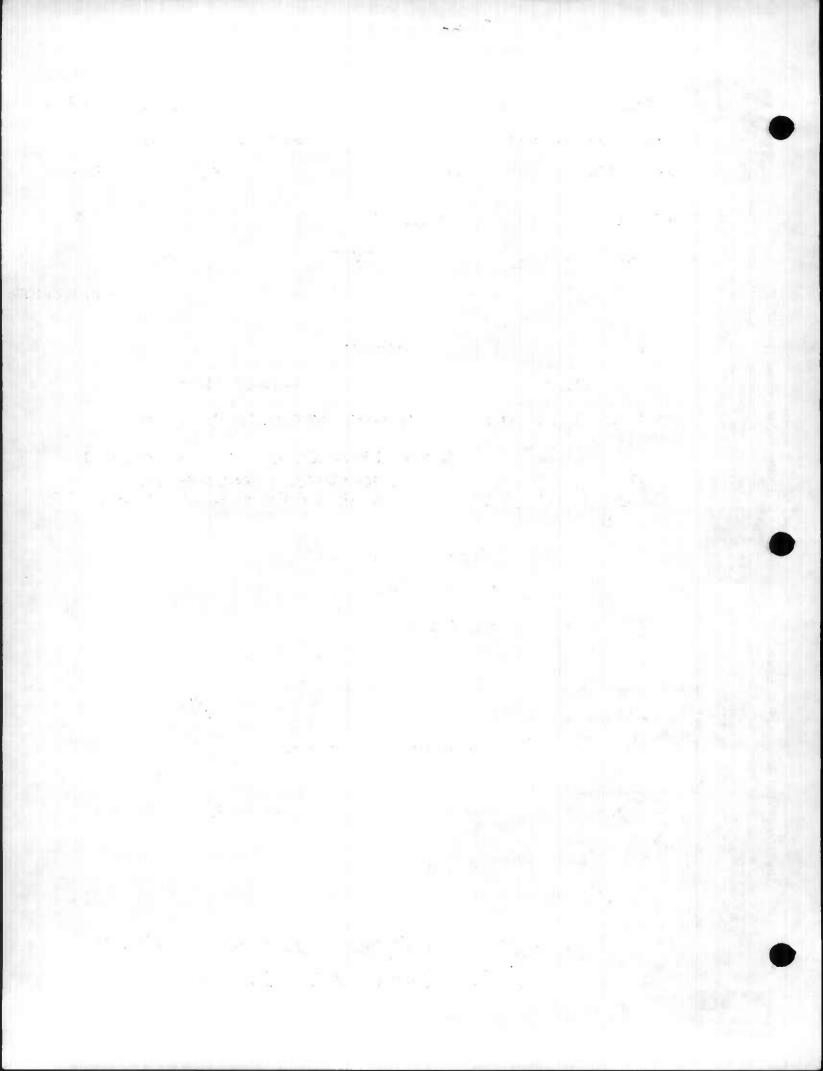
Registrar

31. Dete filed (Month, Dey, Yeer)

141998

32. Registrer's Signeture

Achia Davidson



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death Item#24a.25.26.27 per Phy G761 7/14/98 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month WALSH ELLEN 1 - 20 AM 6 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday).

8 6 Yrs. 5. Social Security Number Birthplace (State or Foreign Country) 1□M 2 F Months 214-64-9137 Oct. 14,1911 Ireland Usual Residence of Decedent 10e. Steta 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore City Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 3725 Ellerslie Avenue 21218 U.S.A. 12. Was Decedant Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2 ▼No If Yes, Give Yaar or Dates: 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) religious order 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Walsh Ellen O'Donnell 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Sister Rita Mary 3725 Ellerslie Avenue, Baltimore, Maryland 21218 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from Stata 4 Donation 5 ☐ Other (Spacify) 21. Signature of Funeral Servica Licensee Ronald S. Wade, 22. Name and Address of Facility Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition rasulting in death) · Bacterial Due to (or as a consequence of) Due to (or es e consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

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Box 68760. certificate be

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

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"natural", or itsms 23a

e filed within 72 hours after al Hygiene. other than "natural", or its

12 should be fi thank Mental F is marked of

permit. Pages 1 and 2 sh Department of Health and Important: If them 27 is m any injury or other traum once.

Baltimore, Maryland 21215-0020

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Certification:

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2 Accident

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certificate

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I Director: After d in by the funer After

24 hours eft Funeral Di Hospital

within 2

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

24b. Were autopsy findings available prior to completion of cause of death?

24a. Was an autopsy performed' 1 Yes 2 ₩ No

25. Was case referred to medical examiner? Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Neturel

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how Injury occurred

26. Place of Death (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD.

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to tha ceuse(s) and manner stated. (Check only one) 29b. Signatura and title of certifies

6 Could not be determined

29c. Licansa numbar D0052628 29d. Date signed (Month, Day, Year)

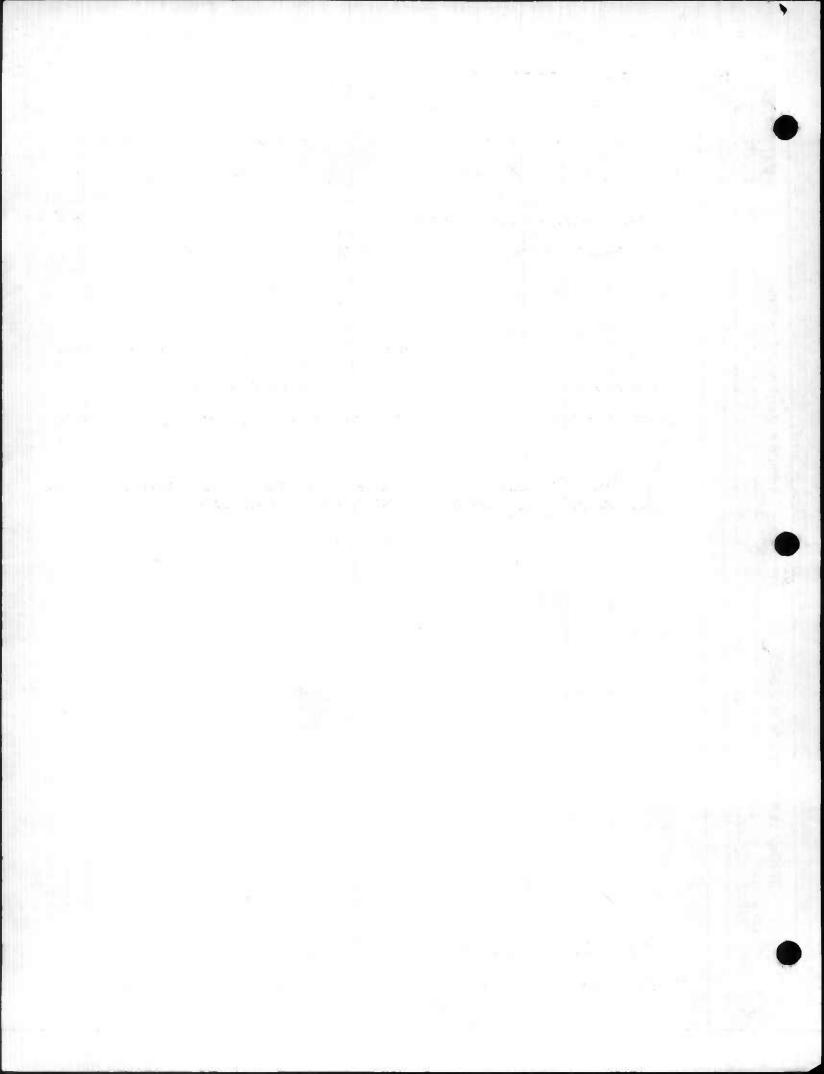
1 ☐ Yes 2 ☐ No

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) SALKINI.

5601 LOCH RAVEN BLUD GOOD SAMARITAN HOSPITAL BALTIMORE MD 21239

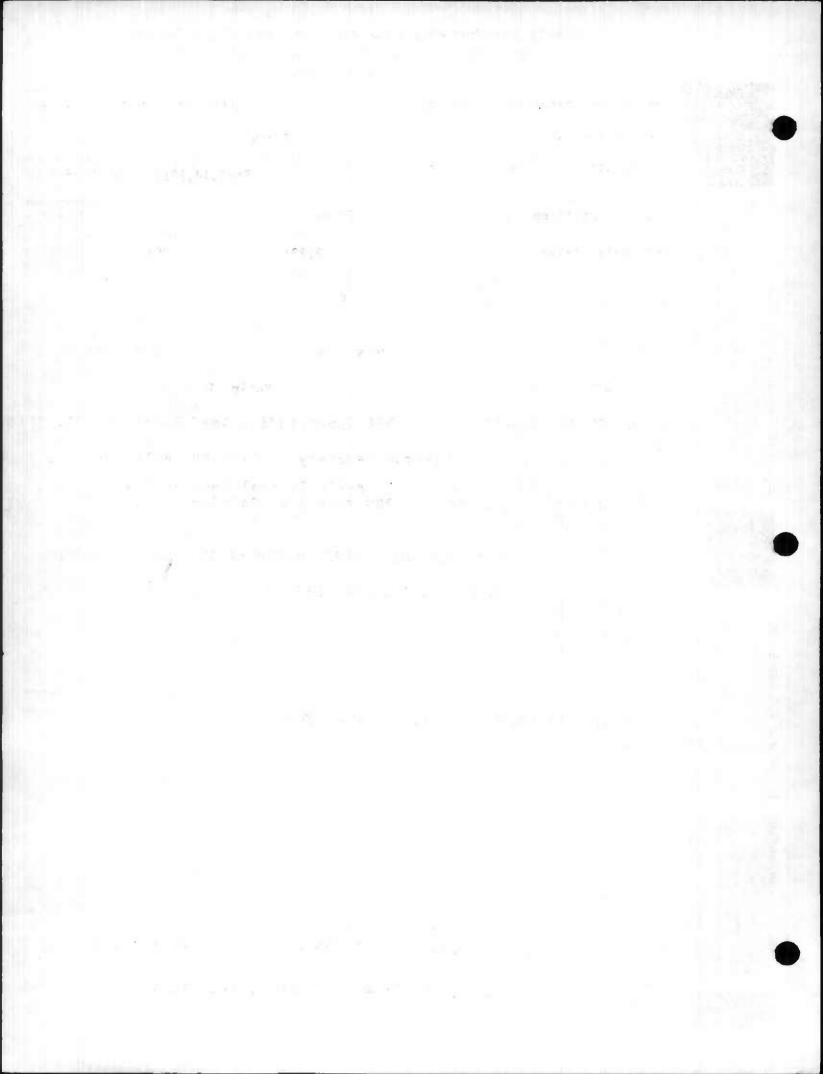
State Registrar

31. Date filed (Month, Day, Year) 32. Regi JUL 141998



State of Maryland / Department of Health and Mental Hygiene 8 2 | 563

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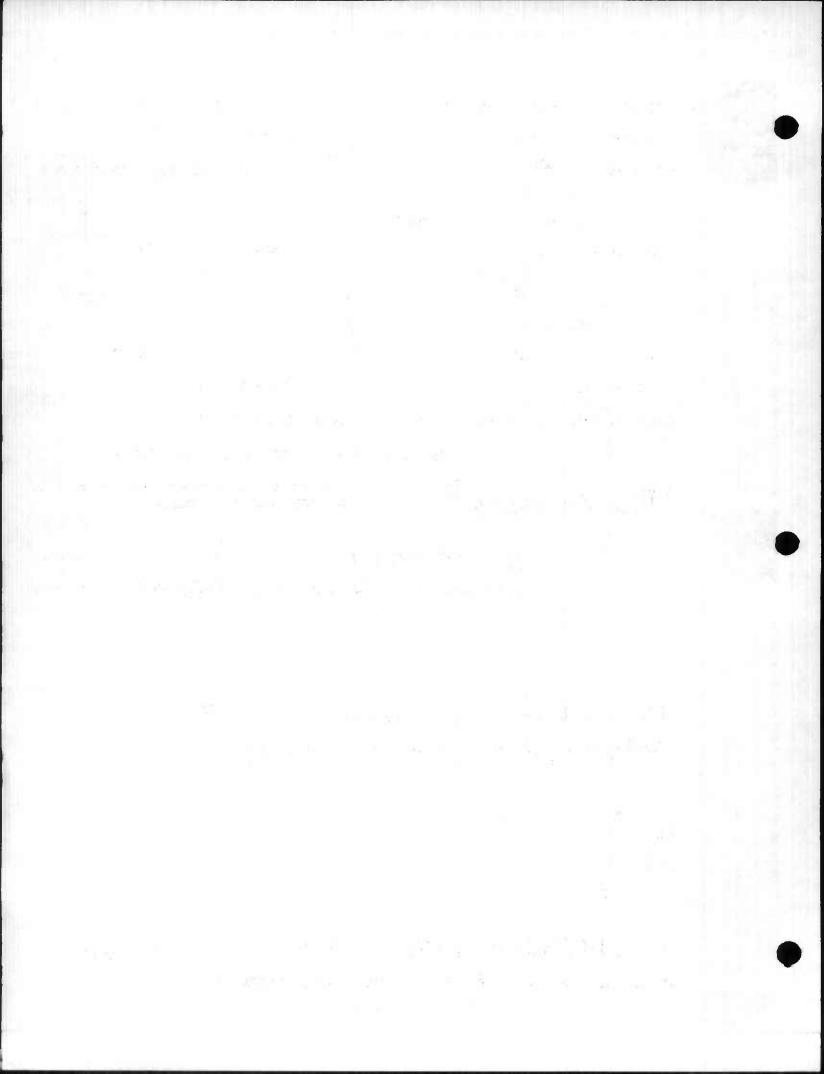
State of Maryland / Department of Health and Mental Hygiene) 8 2 56 4

				Certificate of	Death	Re	g. No.						
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020	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28a-f show he Modical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yas 2 □ No It Yas, Give Year or Dates:	It Yes, specify Cub	ban, Mexicen, Puerto F	cify Yes or No- lican, etc.)	Black, White	, etc.					
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/lar		To B	W. HERBERT ADAMS MARGARET PATRICK										
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1	within 2 To the comple	Me	29b. Signature and title of certifier	29c. Licen	nse number	29	d. Date signed (Month,	, Day, Year)					
1	F > F 0		· Wultwood)		3715		6/30,	198					
			30. Name end address of person who completed ceuse of death (It	am 23a) (Type, Print)			•						

State Registrar

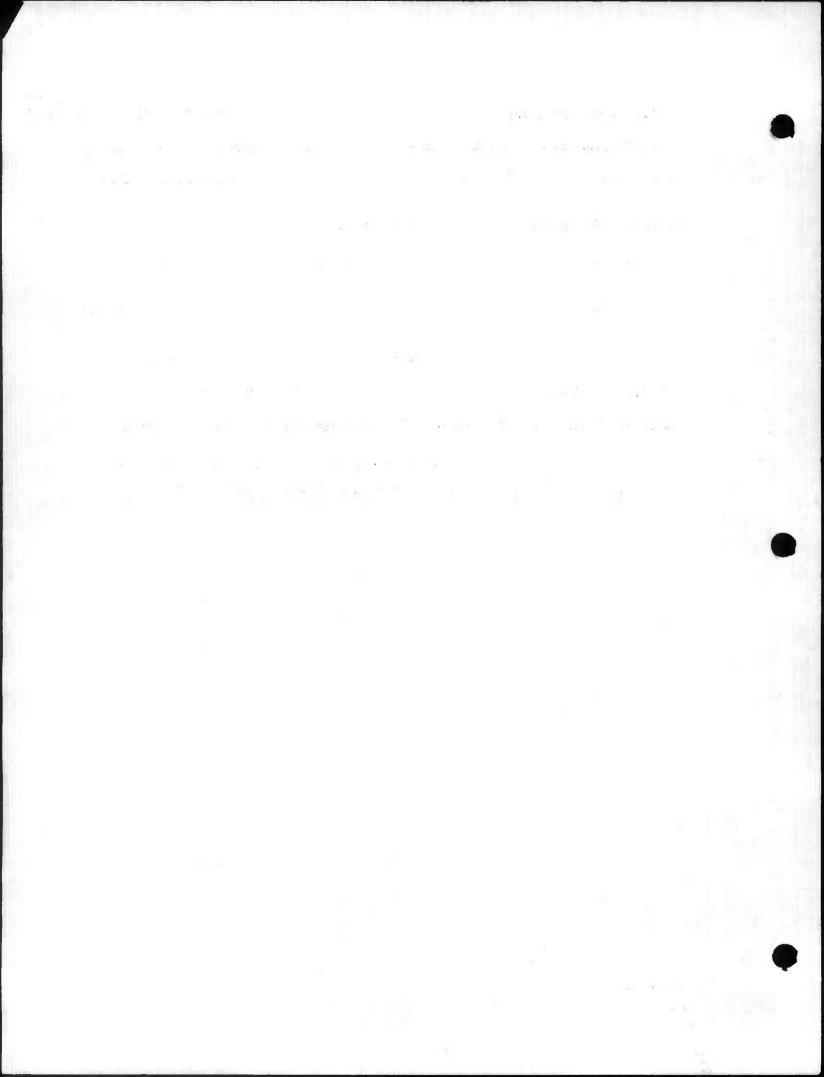
WILLIAM H. WOOD, JR., M.D., 506 IDLEWILD AVENUE, EASTON, MD 21601 31. Dete tiled (Month, Day, Year)

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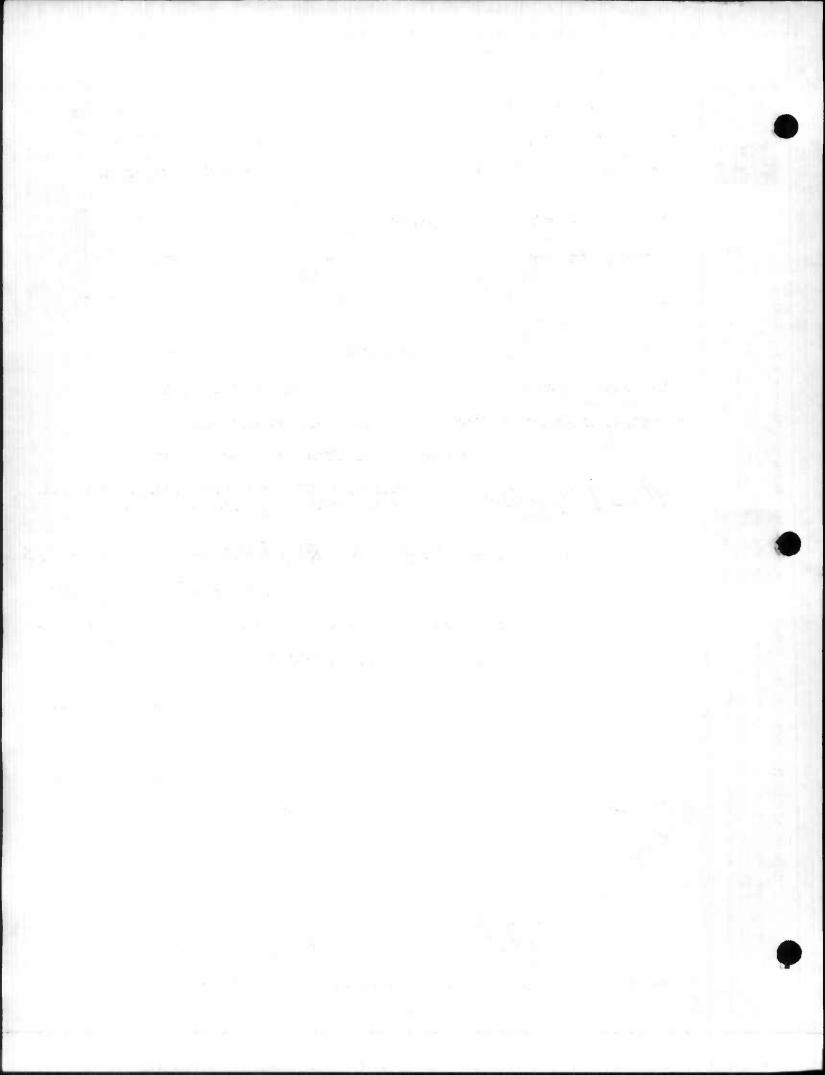
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Baltimore,	pormit. Page Department o Important: If any injury or otice.		4 Donation 5 Other (Specify) Gate of Heaven Cemetery 7/2/98 Silver Spring, Maryland 21. Signature of Funeral Service Licensee												
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	Physical designation	n: To	27. Mannar of Death	28a. Date of Injury	28b. Tima of	28c. Injur	4 KU Nursing F	loma 5 ☐ Rask 28d. Describe I	dence 6 LOth now injury occur						
ion	ath. r: After ne funer	atio	1 Natural 5 Pending 2 Accident invastigation	(Month, Day Year)	Injury M		rk? Yes 2 □ No								
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Sulcida 6 ☐ Couid not be 4 ☐ Homlcida datarmined	Street and Numb vn, Steta)	er or Rural	Routa Num	ber,								
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	within 2 To the comple	Me	29b. Signatura and titla of certifiar	and marrier states.		29c. Licens	a number		29d. Data signe	d (Month, D	lay, Year)				
	f.		Allend	alli Kla	w M.D.	D	4333	23	JUN	6 7	6.1	990			
	P		30. Nama and address of person who co	implated causa of death (Itar	n 23a) (Type, Print)	18	4333 111 PA	2 INCE	PH	ILIF	OF	RIVE			
			Ahede Ali Khan Su		OLNE	y n	ID 2	0833	2 .						
	Sta Registr		31. Data filed (Month, Day, Year)	32. Registrare Signal	Parte R				_						



State of Maryland / Department of Health and Mental Hygiene

						Cert	tificate of	Death		Reg. No.	5 2	1566		
	Dhania	ł	Decedent's Neme (First, Middle, La						2. Dete of De Month		Yaar	3. Time of Death		
	Physic /Medi		Grace Elizabet	h Ball					July	-	98	6:10 AM		
	Exami		4a. Fecility Name (If not institution, give					4b. City, Town, or		h 4c. County	of Deeth			
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-	Funerai Director			Sex 7. Age 1□M 2/□F 8.9	(In yrs. lest birt	Yrs.	Months Deys			nth ay, Year) , 1909	9. Birthpl Count CONN	lece (State or Foraign try)		
	Pue & m	tor	10a. Stete 10b. County		10c. City, Town	or Loca	ation				11	0d. Inside City Limits		
	death with the Maryland ms 23a or 28a-f show		MD TAL	вот	EAS	STON						XXYes 2□No		
	r 28	Director	10e. Street end Number				10f. Zip Code			10g. Citizan of	Whet Coun	try?		
	h wit		601 DUTCHMAN'S L	ANE			216	0.1		USA				
	IOFE, Maryland 21215-0020 ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23s or 28s-4 show or other traumatic event, the Medical Examinational by notified as	Funeral	11. Marital Status	12. Wes Decedent E Armed Forces?	ver in U,S.	13. W		Hispenic Origin? (S pan, Mexican, Puar	Specify Yes or No	ecify Yes or No- 14. Raca - Amarican Indian,				
020		by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorcad	1 Yes 2000 If Yas, Give Yeer or Detes:	0		Tes, specily Cut		no Alcan, atc.)	Specif	ck, White, a	aic. HITE		
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	Il Hygler other ti	S	7	-0-	1	HOME	MAKER	The residence		OWN I				
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Z	should be and Mental I marked of umatic eve	P		COLE				EFFIE	EFFIE TALAMEDGE nber or Rural Route Number, City or Town, Stete, Zip Code)					
Mai	12 she h and h smd 7 ls me traum		19a. Informent's Neme/Ralationship (Code)						
	of Health Item 27 other tr		KENNETH E. RICHAI 20a. Method of Disposition	KDSON/ BROTE			HAFER R(DAD, NEW	HARTFOR	D, CT 06		Charles		
	Pages mant of h ant: If ite ury or of		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif	R, MD	wn, Steta									
Ball	permit. Pag Department Important: F any injury o		21. Signature of Funerel Service Licer	1		RELI	Name and Addr LOWS, HI	T FEMRETN	& NEWN	AM FUNER	AL HC	ME, P.A.		
	Physician /Medical Examiner		23a. Part . Enter the diseese, or com shock, or heert failure. List only	plications that caused	the death. Do n	ot anter	the mode of dy	ing, such as cardie	c or respiretory	N - MD 21 prrest,	601	Approximete Intervel Between		
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	To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: Aftar th completaly filled in by the funeral	edicai	29e. Cartifiar (Check only one) 1 Cartifying Ph 2 Medical Exam	ysician: To the best of ninar: On the basis of and manner stat	mination and	deeth o	stigation, in my	me, dete end piace opinion, daath occi	e, and dua to the urred et the tima,	ceuse(s) and made, data and place,	annar as sta and due to	ated. the ceuse(s)		
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			1/6	17/M/n-	-		H	48241		7/2	198			
			30. Nama end eddress of person who	completed causa of de	eth (Item 23e) (Type, Pi		/- //		//	10			
				AKAS DO	TOK	IN	FWILD	DUE	EASTON	U, mD	2/6	2/		
	Sta	ite	31. Dete filed (Month, Day, Year)	32. Registre	's Signature					7	1 10	1		
	Registr	ar	JUL - 2 199	8 Julia	Davidson	Janol	200							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () AMENDED-ITEM 22-21851-EPW 0626/98 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death 3. Time of Deeth **Physician** Month MARVIN 1130 June /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth UNIVERSITY OF MARYLAND BALTIMORE BALTIMORE If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) Aug. 18, 1967 If Under 1 Year 5. Sociel Security Number 9. Birthplece (State or Foreign Country) Mary Land 7. Age (In yrs. lest birthday) **Funeral** 1⊠M 2□ F Deys 30 213-98-3966 Yrs. Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a Stete 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experient must be notified at 1 ☐ Yes X☐ No Director Willards Worcester 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21874 36243 Pine Street USA Completed by Funeral 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-it Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes X No If Yes, Giva Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedant's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Businass/Industry completed) Elamantary/Sacondery (0-12) Worcester County and Mental Hygiene. Collaga (1-4or 5+) 12th Supervisor Development Baltimore, Maryland 17. Fether's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Meider Pages 1 and 2 should be filt ment of Health and Mental Hyant: If item 27 is marked oth tury or other traumatic eventury or other traumatic eventuals. Be Annie Virginia Byrd Unknown 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Annie Byrd 4224 Betheden Ct. Pocomoke, MD 21853 20b. Plece of Disposition (Name of cemetery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any injury or once. 6/27/98 4 ☐ Donetion 5 ☐ Other (Specify) Pocomoke, MD Sinai Cemetery 21. Signature of Funeral Service License 22. Name end Address of Fecility Bennie Smith Funeral Home 819 4th St. Pocomoke, MD 21853 2 /85/ Part 1. Enter the diseasa, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilura. List only one causa on each line. Approximeta Intervel Between Onset and Daeth **Physician** /Medical Immadiata Ceuse (Final diseese or condition rasulting in deeth) Examiner Examiner ii or Attending Physician: The law requires that the death certificate be executed dering death.

Director: After this certificate has been signed by the ettending physician and clin by the Inneal director, page 2 should be deleched for use as the burlet-transit of in by the Inneal director, page 2 should be deleched for use as the burlet-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Disease or Injury that initiated evants resulting in deeth) Lest Records, P.O. Box 68760, ytomegalovirus Physician/Medicai Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ◯ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Wara autopsy tindings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was casa rafarred to medical examiner? Be 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 28e. Deta of Injury (Month, Dey Year) 27. Mannar of Death Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 D Homicida To the Hospital of within 24 hours of To the Funeral D completely filled in

State Registrar

Medical

29e. Certifian

31. Dete filad (Month, Day, Year)

29b. Signefure end title of cartifier

Street, 32. Registrar's Signature

GLENN

BARQUET NO UMP

Certifying Physicfan: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

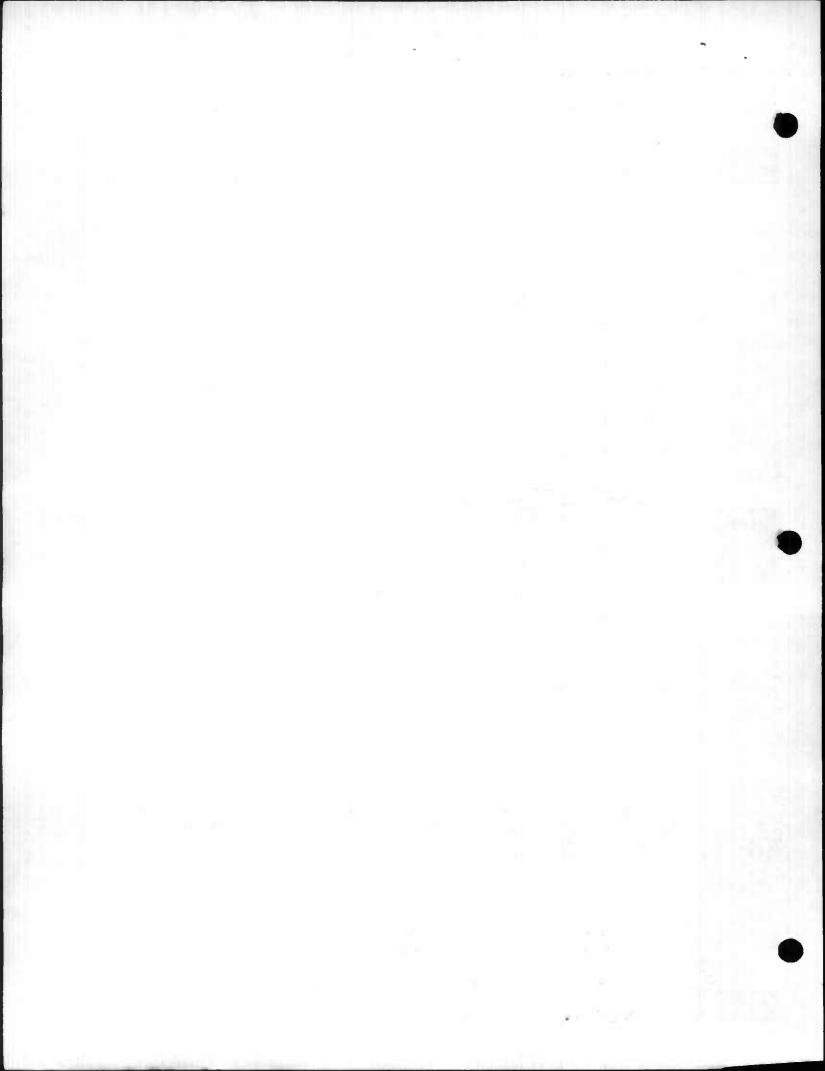
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta end place, and due to the cause(s) end menner stated.

29d. Dete signed (Month, Dey, Year)

Baltimore Hayland

Greene Full Davidson-Randelle JUN 2 6 1998

30. Nama and address of person who completed causa of daath (Item 23e) (Typa, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗦 🖔 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** ABEDNEGO BREWINGTON 16:10 06 27 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner GENERAL WORCESTER HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Sociel Security Number **Funeral** M 2□ F Months 180-24-1995 Director Usual Residence of Decedent 10d. Inside City Limits the Marylend 10b. County 10a. Stete 10c. City, Town or Location 1 Nes 2 No Director 10e. Street end Number 10a. Citizen of Whet Country? na 23a or USA 4030 Funeral . Wes Deredent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, r is marked other than "natural", or frems traumetic event, the Medical Examiner me Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0020 Specify: by 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) lome-Remodeling 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Peges 1 end 2 should be nent of Heelth and Mental EWINGTON 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Philadel thing Pa. 19/19 20c. Location - City or Town, State 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) Baltimore, Burial 2 Cremation 3 Removal from State -7-98 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 71 Wharton, Rd. Wharton Funeral Home-Accom ac Va. 2336 \
Approximate
Interval Between
Onset end Death 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdii shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final diseese or condition resulting in deeth) /Medicai MYOCARDIAL INFARCTION EW MINS Examiner Due to (or as a consequence of): Examiner CUD FEW YEARS Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 □ Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24e. Was an autopsy completion of cause of death? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ■ ER/Outpetient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 5 Pending investigation Hospital or Attending 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and menner es stated.

Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier worte 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 12+

203 SNOW ST, SNOW HAL, MD. 21863

Registrar

State



Ctate of Manuard / Department of Health and Manual Hydiana

ITEM:	#20B PER F.H. G769 3			rtificate of		F	Reg. No.	8 2	1569			
nysician Medical	Decedent's Name (First, Middle, I MARY LC 4a Facility Nama (If not institution, g	UISA BRUEC	KMANN		4b. City, Town, or Lo	2. Date of Dea Month July	Day 2	Year 1998	3. Time of Death			
xaminer		Course Rd.			Ocean Cit				r			
eral ctor			yrs. last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	r, Year)	9. Birthp	laca (Stata or Foreig			
	Usual Residence of Decedent 10a, State 10b, County	100	c. City, Town or L	nantina								
5	Md. Worce		Ocean C						0d. Inside City Limits 1 ☐ Yes 2X No			
"natural", or items 23a or 28a-f show adical Examinar must be notified at leted by Funeral Director	10e, Street and Number				10g. Citizen of	ntry?						
	10347 Golf Cour	se Rd.		21842			US					
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forcas?		Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 🗷 No	Hispanic Origin? (Spe ban, Mexican, Puarto Specify:	ecify Yes or No- Rican, etc.)	Bla	ce - Americack, White, fy: Whi	etc.			
	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of worki	ing	16b. Kind of E		dustry			
	17. Fether's Name (First, Middle, La Otho Harold M		LIDIC	11411	18. Mother's Name							
	19e. Informent's Name/Relationship	n, State, Zip	Code)									
	Theodore Brueckmann 10347 Golf Course Rd., Ocean City, Md. 21842 20a. Method of Disposition 1 Burial 2 © Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State											
l	4 Donatigh, 5 Other (Spec	oify)				6-2-98	Frankf	ord,[Delaware			
	21. Signatura for Virginia Sagilo Lic	ege	T	8 William	age Funer	lin. Md	. 21811					
	20a Phot. Erher the disease, or co shock, or heart failure. List op Immediate Cause (Finel disease or condition resulting in death)	. Metesta		my las					Interval Between Onsal and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): d												
	Part It. Other significant conditions	contributing to death but no	t resulting In the t	underlying cause g	iven in Pert I.	236. Did	obacco use c		the cause of death bably 4 - Unknow			
24a. Was en eutopsy performed? 1 Yes 2 No									ere autopsy findings allable prior to empletion of cause death?			
						101	res 2 No	11	☐ Yes 2☐ No			
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2	1 Yas 2 No 27. Menyer of Death Natural 5 Pending	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie	of 28c. Inju		me 5 Phonic 28d Describe h		ther (Special urred	(y)			
	2 □ Accident invastiget 3 □ Sulcide 6 □ Could not 4 □ Homlcide determine	be con Diana of Initia	At home, farm, st		Yes 2 No	28f. Location (S City or Tox	Street and Num vn, State)	ber or Run	al Route Number,			
enical C		Physician: To the best of my aminer: On the basis of exe										
(256. Signaturi and title of affill or	00	MD	29c. Licar	36278	:	29d. Date sign	ed (Month,	Day, Year)			
	30. Name and address of person who Dr. David E. Co				suite Al	Salis	sbury	Md	21801			
ite ar	31. Date tiled (Month, Dey, Year) JUL 0 2 8	32. Registrar's										

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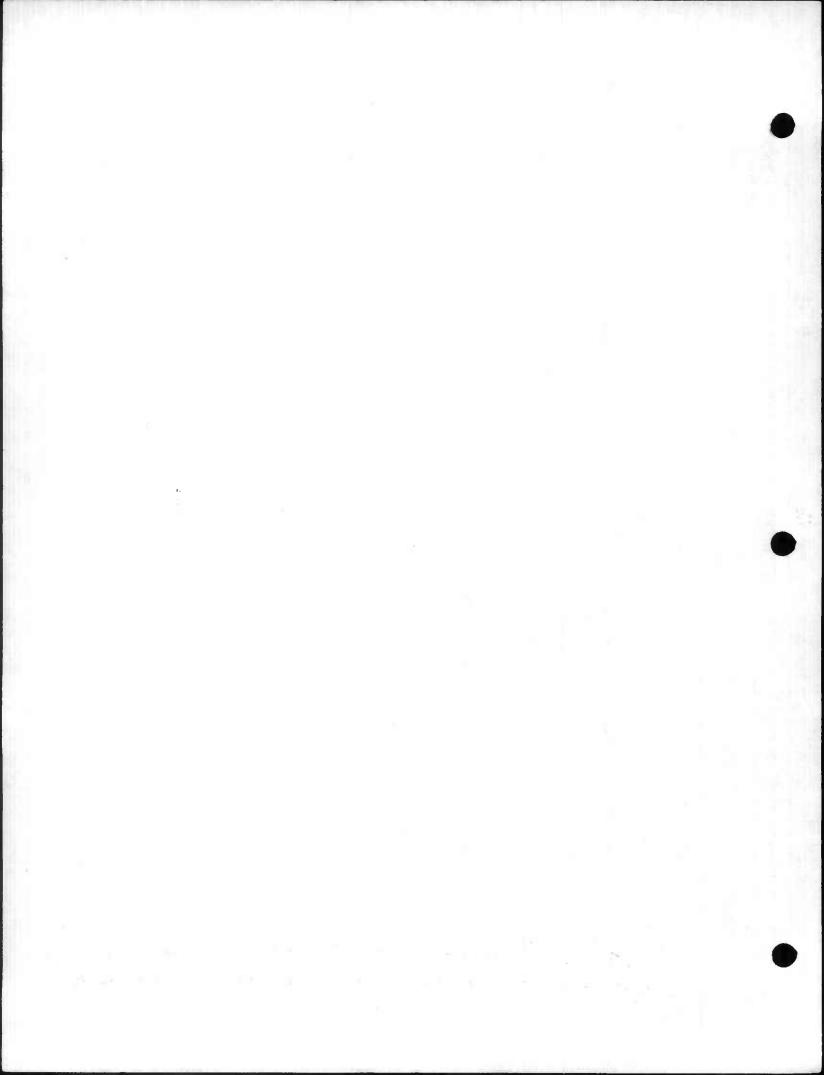
State of Maryland / Department of Health and Mental Hygiene 98 21570

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	Physic	an	Decedent's Name ((First, Middle, L	.ast)					2. Data of D Month	P. Data of Death Month Day Yea		3. Time of Death	
	/Medi		Elena Be	ecker						June			8:20am	
<u> </u>	Exami		4a. Fscility Nama (If n		4b. City, Town, or	Location of Dea	eath 4c. County of D							
			Wilson H	Health	Care Cen	ter			Gaither	sburg	Mo	ntgome	ery	
	Funeral		5. Social Security Nun	nber 6.		7. Age (In yrs.	last birthday	Months Day			irth	9. Birthi	place (State or Foreig	
1	Director		577-56-301	L4	1□M 2気F	83	Yrs.	WOUTHS Day	s riouis wiii.	March	12, 191	5 Ru		
	D.		Usuai Residence of D											
	how		10a. State 1	I0b. County		10c. Ci	ty, Town or I	_ocation				1	10d. tnside City Limits	
	W T	cto	Maryland :	Montgon	nery	Gai	thersl	ourg					1⊠Yes 2□No	
	# 22 F	lre.	10e. Street and Numb	er				10f. Zip Code	6		10g. Citizen o	f What Cour	ntry?	
	11 wi	ai C	201 Russel	ll Aven	ue			208	77		Unit	ed Sta	ates	
	72 hours efter death with the Maryland natural', or Nema 23a or 28a-f show dical Examiner must be notified at	Funeral Director	11. Maritai Status			edent Ever in U	I,S. 13	. Was Decedent of	Hispanic Origin? (Suban, Mexican, Puer	pecify Yes or N	o- 14. R	14. Race - American Indian,		
0	offer and and and and and and and and and and	F	1 Nevar Married	2 Married		2 No				o Hican, etc.)	В	iack, White,	etc.	
020	or and	by	3K Widowed 4	□Divorced	If Yes, Giv Year or D	/e ates:		1 ☐ Yes 2 🖾 N	o Specify:		Spec	Day Year 1998 8:20 am 4c. County of Death Montgomery 9. Birthplace (Stete or Fore Country) 1915 Russia 10d. Inside City Lim 12 Yes 2 Citizen of What Country? United States 14. Race - American indian, Biack, White, etc. Specify: White Kind of Business/Industry S. Library of Conglien Sumame) by or Town, State, Zip Code) 11e, Hawaii 96722 Location - City or Town, Stata exandria, Virginia al Home Approximate interval Between Onset and Death 3		
0-0	72 hours "natural",	ted		5. Decedent's I	Education		18a. Dec	edent's Usual Occ	upation		16b. Kind of			
218	C .	ple	(Specify Eiamentary/Second		rade completed) College (1	(Ant Ex)	(Giv life.	e kind of work don DO NOT usa reti	e during most of wo red)	rking				
21	filed within Hygiene.	Completed	Clambridary/3600riu	lary (U-12)	5+		Ca	taloger			U.S. L	ibrar	v of Congr	
ğ	be filed d other	Bec	17. Father's Name (Fi	rst, Middla, Las	it)		, , ,		18. Mother's Nar	ne (First, Middle				
a	Mentel Merked of arked of artic eve	ToB	Alexander Alexandrov Evdokia Belan											
Ž	d 2 should be filed th end Mentel Hygi 7 is marked other traumatic event,	-	19e. Informent's Nam				19b. Mai	ling Address (Stre			ber. City or Tow	m. State. Zir	n Code)	
Maryland 21215-0020	d d d d d d d d d d d d d d d d d d d					\					-			
e)	of Health of Health f Hem 27 or other tr		Irene Thompson (daughter) 5137 Napookala Circle, Princeville, I 20a. Method of Disposition (Name of Date 20c. Location - C											
0			1 ☐ Burial 2280	Cremation 3		Stata	cematary, cr	ematory or other p						
듶	tme tant		4 □ Donation 5			Met	ropol	itan Cre	matory	6/28/98	Alexan	dria,	Virginia	
Baltimore,	permit. Peges Depertment of Important: If it any injury or once.		21. Signatura of Fune	rai Service Lice	91-11						neral H	ome		
	00760		23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feliure. List only one cause on each line.											
			23a. Part . Enter the	disease, or con	mplications that c	aused the deat	th. Do not e	nter the mode of d	ying, such as cardie	or respiratory	arrest,		Approximate	
а	Physician													
и	/Medical		immediate Cause (Final disease or condition										311+06	
	Examiner		resulting in death) Bue to (or as a consequence of):										2000	
4		ner	b. pulmonary fibris										Vear	
	deeth certificate be executed e attending physician end od for use as the buriel-transit	in a												
ó	an er riel-t	EX.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.											
68760,	sicia e bu	cal	mat mitiated events		C	Due to /o	or as a conse	ediance of).						
89	ng phy as th	Po	resulting in death) Las	st		D 40 10 (c	7 45 4 CONSC	quarios ory.						
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	es that the igned by the be detache	P .	Con	ustre	_ he	2ut	fail	uve		1	Yes 25-No	3 Pro	babiy 4 Unknow	
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šec	9 2 N	du										of	death?	
	E ag	3								1□	Yes 2 No	- 1[☐ Yes 2☐ No	
/Ita	ysicien: The s certificate director, pag	Be	25. Was case referred examiner?	to medical					28. Place of De	th (Check only	one)			
of Vital	G 10 %	2	1 ☐ Yes	5			ER/Outpation	ent 3 DOA	Other: A Nursing H	lome 5 ☐ Res	idence 8 🗆 O	ther (Specia	fy)	
2	h. After ti funera		27. Manner of Death	5 Pending	28a. Date ((Mont	of injury th, Day Year)	28b. Tima injury		ury at ork?	28d. Describe	how injury occ	urred		
.0	Attending r death. ector: After by the fune	atle	2 Accident	investigation	on				☐ Yes 2☐No					
Division	er de	t t	3 ☐ Suicida 4 ☐ Homicide	6 Could not determine	259. PIECE	of injury - At h	ome, farm, s	treet, factory, offic	0	28f. Location	(Street and Nur own, Steta)	nber or Run	al Route Number,	
	ed in	Certification:			Dangil	a, c.a. (apaul	.,			5, 5. / (, 5.5.4/			
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	180	29a. Certifier 15	Certifying P	hysician: To the	best of my kno	wledge, dea	th occurred at the	time, dete and place	, and due to the	cause(s) and	manner as s	stated.	
	n 24 n 24 ne Fi	edical	one)	_ Madicat Exa	miner: On the ba and mann	isis of axamina nar stated.	tion and/or i	nvastigation, in my	opinion, death occu	irred at the time	, date and place	a, and due to	o the cause(s)	
	With To the	Σ	29b. Signiffure and titl	e of certifier	11411	'n		29c. Lica	nse number		29d. Data sign	ned (Month,	Day, Year)	
				10	Mil	and DIGLEY JUNE 27						27	1888	
\	0	-	30. Name and address	of person who	completed caus	e of death (item	0.55	1			5 -100		,,,	
	3	- 1	7 1	- Paramit Hill			, / , } }	A 4	C1	PAD.	0 01	7	0	

32. Registrar's Signature

Jaha Davidson-Randelle

State Registrar



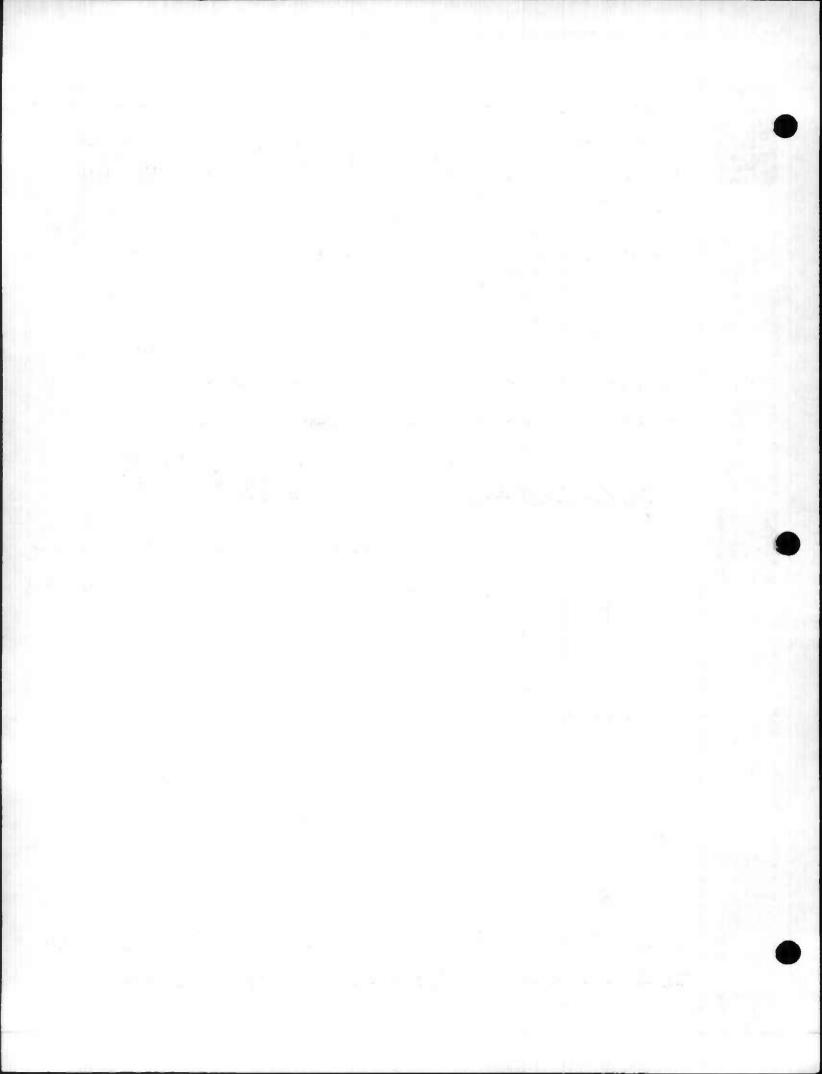
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 30, 1998 Gladys Nichols Bridewell June 5:40 AM /Medical 4e. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lavhill Center Silver Spring Montgomery Year If Under 24 Hrs. B. Date of Birth Deys Hours Min. March 16,1914 Alabama 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Deys Months 84 Yrs. Director 412-10-7394 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location show 10d. toside City Limits must be notified at MD Montgomery Bethesda 1 ☐ Yes 2 No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6603 Old Stage Road 20852 USA or items ? 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 14. Race - American Indian, Bleck, White, etc. 11. Marital Stetus Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) the Medical Examiner filed within 72 hours after 1 ☐ Never Merried 2 ☐ Marrled 21215-0020 Specify: White 1 ☐ Yes 2 No Specify: λq 3 HWidowed 4 □ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Artist Art other traumetic event, Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Surname) . Pages 1 end 2 should be fill ment of Health end Mental Hilant: If item 27 is marked oth Be William Raymond Nichols Nancy Irene Vandiver 19a. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 6603 Old Stage Rd. N. Bethesda, MD 20852 Jacqueline B. Eig/Daughter other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Buriai 2 ☑ Cremation 3 □ Removal from State 0 Department of fmportant: If any injury or 4 □ Donation 5 □ Other (Spacify) Metropolitan Crematory 6/30/98 Alex., VA 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive 21. Signature of Funeral Service Licensee Hilbons Gaithersburg, MD 20877 23a. Pert Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Interval Bety Onset and Death **Physician** CONGESTIVE FAILURE /Medical Immediate Causa (Final HEART 4425 diseese or condition resulting in death) **Examiner** Examiner Hypertansion The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury that initiated evants resulting in deeth) Lest and P.O. Box 68760. physician Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying ceusa givan in Part I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 ☐ Unknown signed Records, þ should be 24b. Wara autopsy findings evailable prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: The safter death.
I Director: After this certificate director. Be 25. Was cese referred to madical examinar? 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 ☐ Could not ba 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Streat and Number or Rurel Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital of within 24 hours at To the Funeral D complately filled in 29a. Cartifier (Check only one) Certifying Phyaician: To the basi of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) JUNE, 30Th, 1998 10 30. Name and addrass of parson who complated cause of death (Itam 23a) (Typa, Print) DR GAURANG THAKER 18111 PRINCE Philip DR., #212 OLNEY, MD 20832 31. Date filed (Month, Day, Year)
JUL 0 2 1998 32 Registrar's Signatura State Julia Davidson-Randelle Registrar

DHMH 16 Ray 6/95

Brus



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8:06 PM **Physician** Ward Leslie Brower June 27, 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10XM 2□ F 75 Yrs 227-20-1979 Director Nov. 22, 1922 Virginia Usual Residence of Deceden with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1013 Roswell Drive 20901 USA Funeral death Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or not of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or its 1 XYes 2 No 1 Never Married 21X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: À 3 Widowed 4 Divorced Year or Dates: WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Printer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Russell Wade Brower Alberta Elizabeth Johns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Anne K. Brower (wife) 1013 Roswell Drive, Silver Spring, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State ò Department of Important: If 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 7/2/98 | Silver Spring, MD Francis J. Collins Funeral 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 500 University Blvd. West Home, Inc. Selvan Silver Spring, MD 20901 Approximate Intervel Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. **Physician** lung Cancer /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical the Due to (or es e consequenca of): 88 USB 10 ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? o signed by t 1 No 3 Probably 4 Unknown Division of Vital Records. P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific director. Be 25. Was case referred to medicat 26. Plece of Deeth (Check only one) examiner' Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) completaly 2 Medical Examinar: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, dete and place, end due to the cause(s) end menner steted. To the within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1241 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 102277

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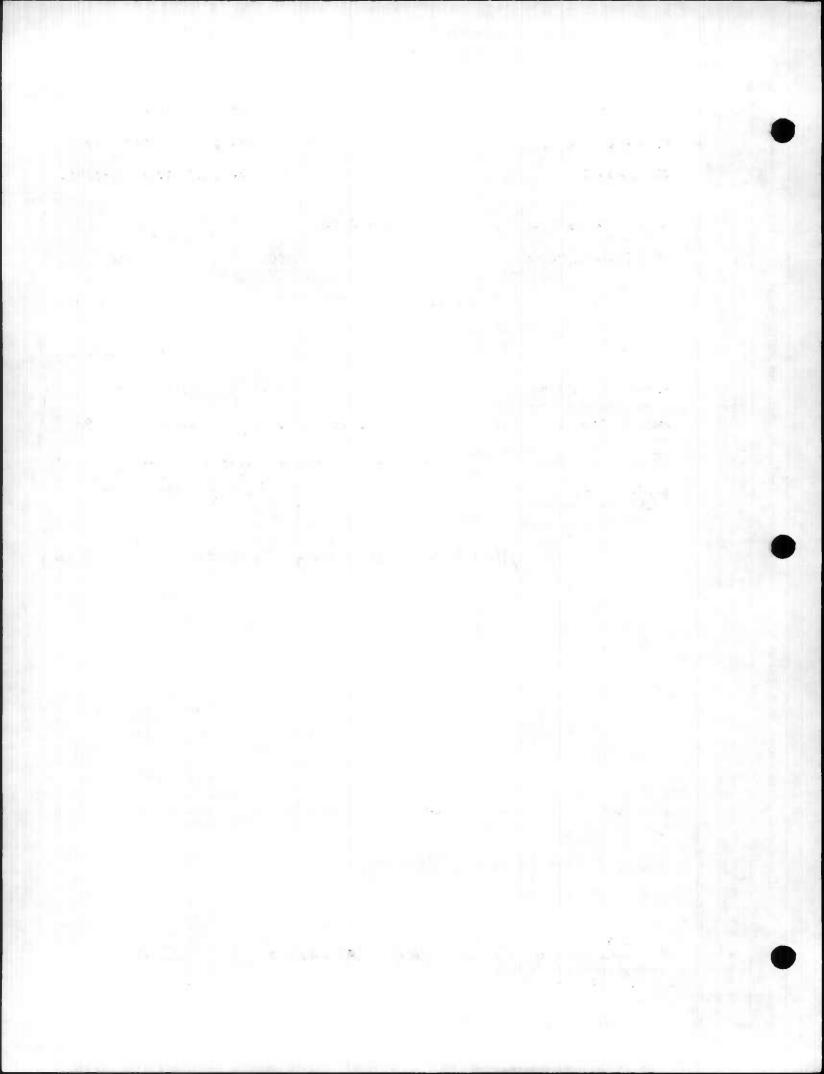
State Registrar

31. Date filed (Month, Day, Year)

JUN 3 0 1998

ghis Deviler Andelle

Frederick G Barr, M.D., 2101 Medical Park Drive, Silver Spring, MD



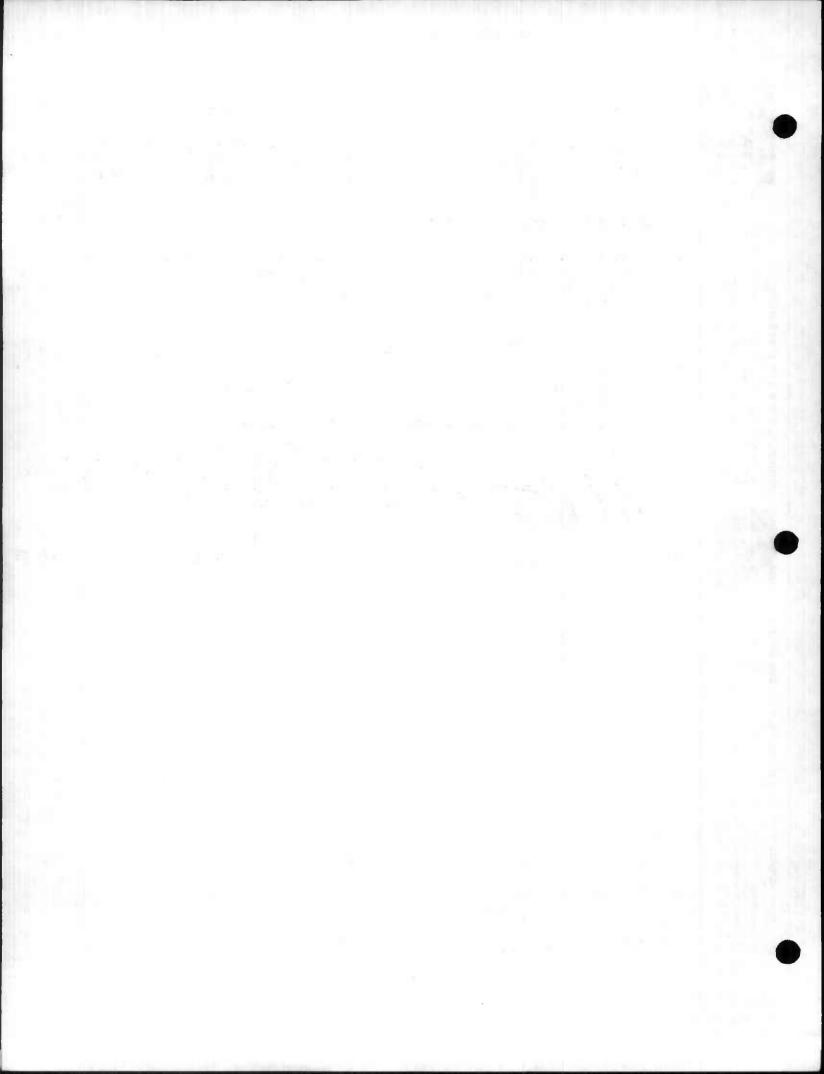
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State of Maryland / Department of Health and Mental Hygiene

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						Cer	tificate	of De	ath		Reg. No.	, 0	41010	1
	-		1. Decedent's Neme (First, Middle, L	ast)	2 -					2. Dete of Dec	eth	Mali	3. Time of Death	
	Physic /Medi		6015	M.	BR	AD	V			JUNE	27	1998	1855	
	Exami		4e. Fecility Nema (If not institution, g	ive street end number)			/	4b. C	ity, Town, or I	Location of Deeth				
			Holy Cross Hospi	tal				Si	lver S	pring	Montg	gomery	у	
	Funeral		CARLETT LANGUE CONTRACTOR	Sex 7. Ag 1 ☐ M 2 ☑ F	e (In yrs. last b		If Under 1 Y Months D		Jnder 24 Hrs. ours Min.	8. Dete of Birt (Month, De	h v, Year)	9. Birthpi Coun	lece (State or Foreign	m
(0)	Director		441-05-5372	7. W 2M	89	Yrs.				May 15,	1909		ahoma	
	pue M		Usuel Residance of Decedent 10e. State 10b. County		10c. City, Tox	wn or Loc	cation					10	0d. Inside City Limits	2
	Vanyl 1 she	5	Maryland Montgon		Rocky	-211							1 ☐ Yas 2 ☒ No	
	the 128s	Director	Maryland Montgon	lery	ROCK	1116	10f. Zip Co	de			10g. Citizen of	What Coun	in/?	_
	with Ba or		14635 Bauer Drive	Apt 100				353 - 2	402		United			
	Jeath Tre 2	Funeral	11. Maritel Stetus	12. Was Decedent	Ever In U.S.	13. V				pecify Yes or No-		ce - America		
0	of he	E	1 Nevar Merried 2 Married		No					pecify Yes or No- o Rican, atc.)	Bla	ck, White,		
05	al',	by	3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2⊠	No Sp	ecity:		Specif	y: Wh	nite	
21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Exeminer must be notified at	Completed	15. Decedent's I (Specify only highast g	Education	186	e. Deced	ent's Usuel O	ccupation	a most of wo	rkina	18b. Kind of B	usiness/ind	lustry	
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e,	Health Health em 27 I		Barbara J. Cunni	.ngnam/Daug	DOL DI	of Dianas	talam /Alama				20c. Location		the same of the sa	-
altimore,	pennit. Pages 1 end 2 should be filed within 72 hours after death with the Maryler December of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28ad show my injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Buriel 2 ☑ Cremetion 3		cemet	ery, crem	etory or other	place) J	uly 1,	1998				
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ä	Dep Pen		b. 1+ 1	10 1	M01126	Ro	ckvill	e, I	nc., 3	00 West	Montgom	iery A	venue,	-/
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	Examiner		disease or condition resulting in deeth)	0.	Dua to (or as e			>//	941	DKOME			3 MOUN	17.
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o.	the dr	iysi	Pert II. Other significent conditions	contributing to death bu	ut not resulting	in the un	derlying cause	e given In	Pert I.	12.412.5		-	the cause of death?	
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5		o Be	exeminar?	Hospitel:	nt 2 ER/O	utoetient	3□ DOA	Other:		oth <i>(Check</i> on <i>ly</i> of lome 5 Resid		er (Specifi	4)	-
O	g Phys er this neral d	n: T	27. Manner of Deeth	28a. Dete of Injur	y 28b.	Tima of		Injury at Work?	_ Italianing II	28d. Dascribe h			,	
DIVISION	ath. r: After ne funer	atlo	1 Panding 5 Panding 2 Accidant Invastigetic	(Month, De)	r rear)	Injury		1 ☐ Yas	2 □ No					
<u> </u>	r Atte	Certification:	3 Suicide 6 Could not to determined	28e. Plece of Inju- building, ato	ry - At home, f	erm, stre	et, factory, off	fice		28f. Location (S City or Tow	treet end Numb	er or Rura	Route Number,	
בֿ	ins eff													
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral process.	edical	(Check only 21 Medical Exa	hysician: To the bast o minar: On the basis of	f my knowledg	a, death	occurred et th	ne time, de	eta and place	, end due to the o	euse(s) and me	and due to	ated.	
	the I	Med	one)	end menner ste	ted.									
	S V V V		29b. Signature and title of certifier	115-	1			cansa nun			29d. Data signe			
)	6		JUNE 28, 1998 30. Name and addressed person who completed gives of dight (Itam 23a) (Type, Print) Toseph M. HAGGERTY MD 9707 MEDICAL CTR DR ROCKVILLE MD 20850										448	
		4	30. Name and address for person who	completed/celuse of de	eth (Itam 23a)	(Type, P	Print)	י מד	00	er dier a	MX	2.0	~	
	- C4-	•	31. Dete filed (Month, Dey, Yaar)	32 Registre	or's Signetura			IK I	DK KO	cknine	مل- دا	008	50	
	Sta	re		1000		. 70.	dell							

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Day **Physician** 4, Jean Yvonne Bolling 1998 6:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 5059 Gina Lane Federalsburg Caroline If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Days 1 M 2 F 217-38-2399 59 Yrs. Director 04/01/39 W. Virginia Usuel Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limita 28a-f show trsumetic event, the Medical Examinar must be notified at MD Caroline Federalsburg 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Herns 23a 5059 Gina Lane 21632 United States Funeral 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "natural", or item any injury or other transments. 1 ☐ Yes **3/** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Secretary/Pianist Hospital/Churches 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Howard Vest Mabel Scott 2 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5059 Gina Lane, Federalsburg, MD 21632 Robert F. Bolling/Husband 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Bloomery Cemetery 5/7/98 Federalsburg, MD 21. Signature of Funeral Service Licanses 22. Name and Address of Fecility Framptom-Hawkins-Eskow Funeral Home, PA Eskow 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, App. Approximate Interval Between Onset and Death **Physician** 52 mgs /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physician end s the burial-transit The law requires that the death certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of) 88 use for ed by the a Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown þ been sig 24b. Were autopsy findings available prior fo completion of cause of death? 24a. Was an autopsy performed? Completed page 2 has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Division of Vital Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificalete filled in by the funeral director; Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medicel Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifiel To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture an 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and add of person who completed cause of death (Item 23a) (Type, Print) Smith, M.D. 509 Idlewild Ave., Easton, MD 21601 David H. 31. Date filed (Month, Day, Year)

32. Regisfrar's Signature

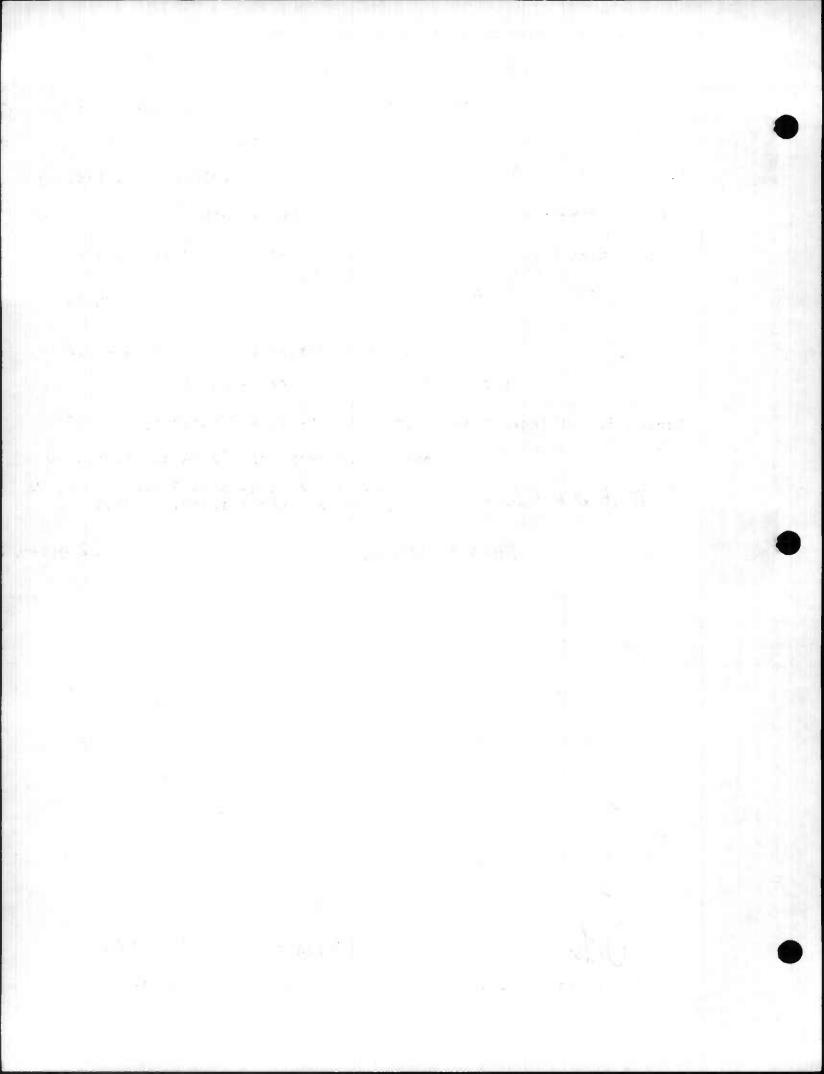
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DHMH 16 Rev 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Deeth Day Month Vesi **Physician** Herbert E. Brown June 1998 /Medical 26 6:27 A.M. 4e. Fecility Name (If not institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll County General Hospital Westminster Carroll If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 152 M: 2 □ F Vrs 61 Director 218-36-6900 Mar. 20, 1937 Maryland Usual Residence of Decedent the Maryland show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or Itema 23a or 28a-f sh idical Expriner nast be notfiled 1 Yes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 64 South Bishop St. 21157 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 14. Race - American Indian, end 2 should be filed within 72 hours after or aalth end Mentel Hygiene. n 27 is merkad other than "natural", or Itei Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No f Yes, Give 21215-0020 1 ☐ Yes 2 ☑ No Specify: py Specify: White 3 Widowed 4 Divorced Year or Dates: Completed permit. Pages 1 and 2 should be filed within 72 ho Depertment of Haalih and Mentel Hygiene. Important: If Itam 27 Is marked other than "natur any Injury or other treumatic avent, in Medica 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Landscaper Landscaping Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be James Robert Brown Elzena (MAiden NAme unknown) 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Terence E. Brown (Son) 1588 Smiley Rd. New Windsor, MD 21776 Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 4 ☐ Donation 5 ☐ Other (Specify) 29, 1998 Sunshine, MD Mount Carmel Cemetery 21. Signature of Funeral 5 22. Name and Address of Fecility once. Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediete Cause (Final diseese or condition resulting In deeth) /Medical Matastatic Head and Neck Cancer 13 months Examiner Due to (or as e consequence of) Examiner Hypercalcemia 5 days The lew requires that the death certificate be axecuted buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury and Due to (or as a consequence of) P.O. Box 68760. ettending physician Physician/Medical Hypokalemia 5 days the that initieted events resulting in death) Last Due to (or as a consequence of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? the 6 1 Yes 2 No 3 Probably 4 Winknown signed t Records, þ page 2 should Completed 24b. Were eutopsy findings evailable prior to 24a. Was an autopsy Deen completion of cause of death? certificate hes 1 Yes 1 ☐ Yes 2 ☐ No 2 No of Vital Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2K No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Sich Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of Injury Certification: 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide

al or Attending P s after death.

M Director: After t ed in by the funers To the Hospital o within 24 hours at To the Funerel D

> Dr. Lisa Kim Carroll County General Hospital 200 Memorial Ave. Westminster, MD 21157 31. Date filed (Month, Dey, Year)

> > JUN 2 9 1998

jun, m.D

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medicai

State

Registrar



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

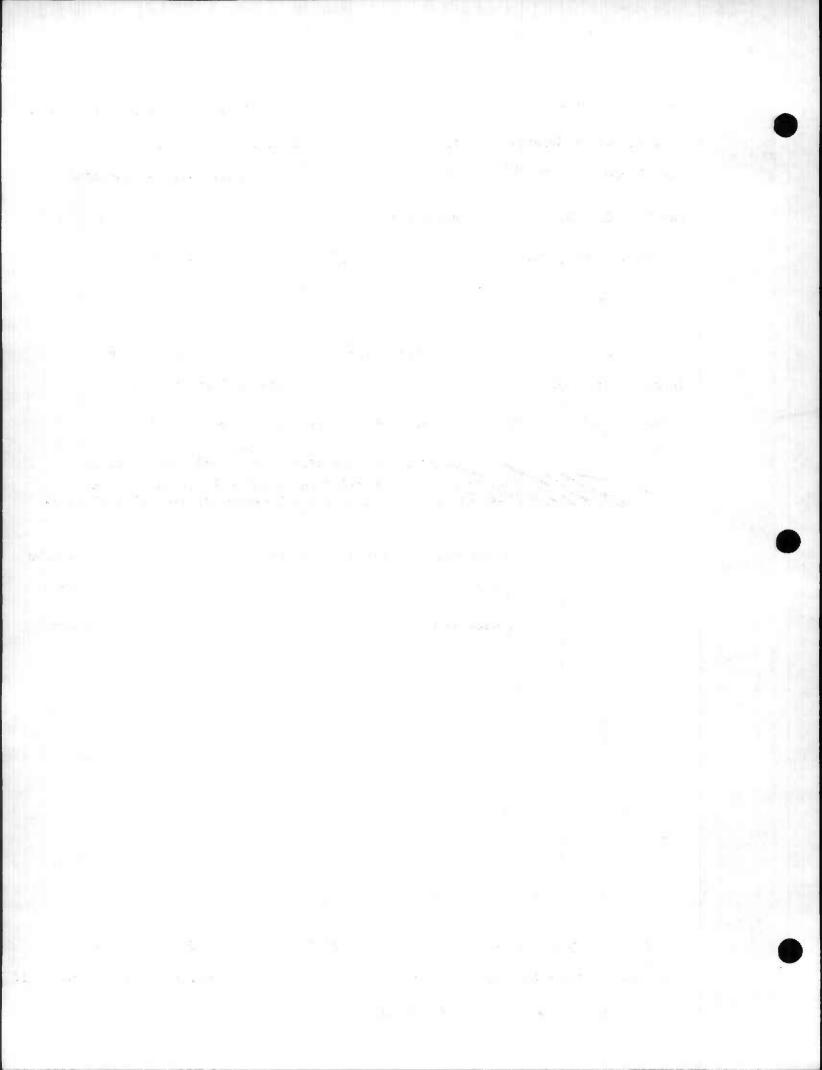
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0052479

29d. Date signed (Month, Dev. Yeer)

June 28, 1998



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

end: #1 Per	DB Per MD Film G761 7-2	-98RC	Certificate of Death	Reg. No.	18 21576
Physician /Medical Examiner	Decedent's Name (First, Middle, Las MUTHER Much Hard Market	. Bolden	4b. City, Town, or	2. Dete of Deeth Month Day Location of Deeth 4c. County	3. Time of Death
Funeral Director	415-18-4248		st birthdey) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min.		9. Birthplaca (State) Foreign Country) Tennessee
ith the Maryland or 28a-f show se notified at Director	Usual Residence of Decedent 10a. State 10b. County		Town or Location		10d. Inside City Limi
vith the Maryla t or 28a-f sho be notified at Director	MD Temple 10e. Street end Number	mii ren	nple Hill 10f. Zip Code	10g. Citizen of	What Country?
urs after death v ar, or thems 23s Examiner must by Funeral	4005 Danville Dri 11. Maritai Stetus 1□ Never Married 2□ Married 3≦ Widowed 4□ Divorced	.VC 12. Wes Decedent Ever in U,S Armed Forces? 1 □ Yes 2 No # Yes, Give Year or Dates:	20748 . 13. Wes Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:		ace - American Indian, eck, White, etc. ^{th/:} Black
P S S S S S S S S S S S S S S S S S S S	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b. Kind of I	Business/Industry
be file d othe event	17. Father's Name (First, Middle, Last)			wife Childo me (First, Middle, Maiden Suma ailable	
	19a. Informant's Name/Relationship (7) Patricia A. Greer 20a. Method of Disposition 1□ Burial 2□ Cremation 3□	n/ Niece	19b. Mailing Address (Street and Number or R 4005 Danville Dr. Temporal of Disposition (Name of Interpolace)	ural Route Number, City or Town	
Department of the Control of the Con	23e. Part Enter the disease, or compensation of the part failure. List only to immediate Cause (Final disease or condition resulting in death)	a. Sep	Pri-State Funeral S Do not enter the mode of dying, such as cardle as a consequence of:	Services 814 Up c or respiretory errest,	Approximate Interval Between Onset and Death
seth certificate be assocuted attending physician and for use as the burial-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	. Hypen	as a consequence of): natriania as a consequence of): atrox		
as that the death certigened by the attending be detached for use a by Physician/M	Pert II. Other significant conditions co	•	ting in the underlying cause given in Pert I.	23b. Did tobacco use c	ontribute to the causs of dea 3 ☐ Probably 4 ☐ Onkn
aw requir.				24e. Wes an autopsy performed?	24b. Were autopsy finding available prior to completion of cause of death?
ystcian: The last certificate he director, page	25. Was case referred to medical		28 Place of De	1 ☐ Yes 2 No ath (Check only one)	1 ☐ Yes 2 ☐ No
Physici this cer al direc	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 □ E	Other	lome 5 ☐ Residence 8 ☐O	ther (Specify)
After the funeral fune	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	28b. Time of Injury at Work? M	28d. Describe how injury occur	
2442	4 Homicide determined		ne, ferm, street, fectory, office	28f. Location (Street and Nun City or Town, Stete)	
To the Hospital within 24 hours a within 24 hours a completely filled Medical Ce	(Check only 2] Medical Exami	ner: On the basis of examination end menner stated.	on and/or investigation, in my opinion, death occ	urred at the time, date and place	s, and due to the cause(s)
or with the second	290. Signature and office of certifier	orden in	29c. License number 5 º 4 5 4	June, WASH	15, 1998
(4)	ARASTOO NA	empieted cause of death (Item 2	132) Souther n	Du. WASH	ingtos D.C.

Registrar

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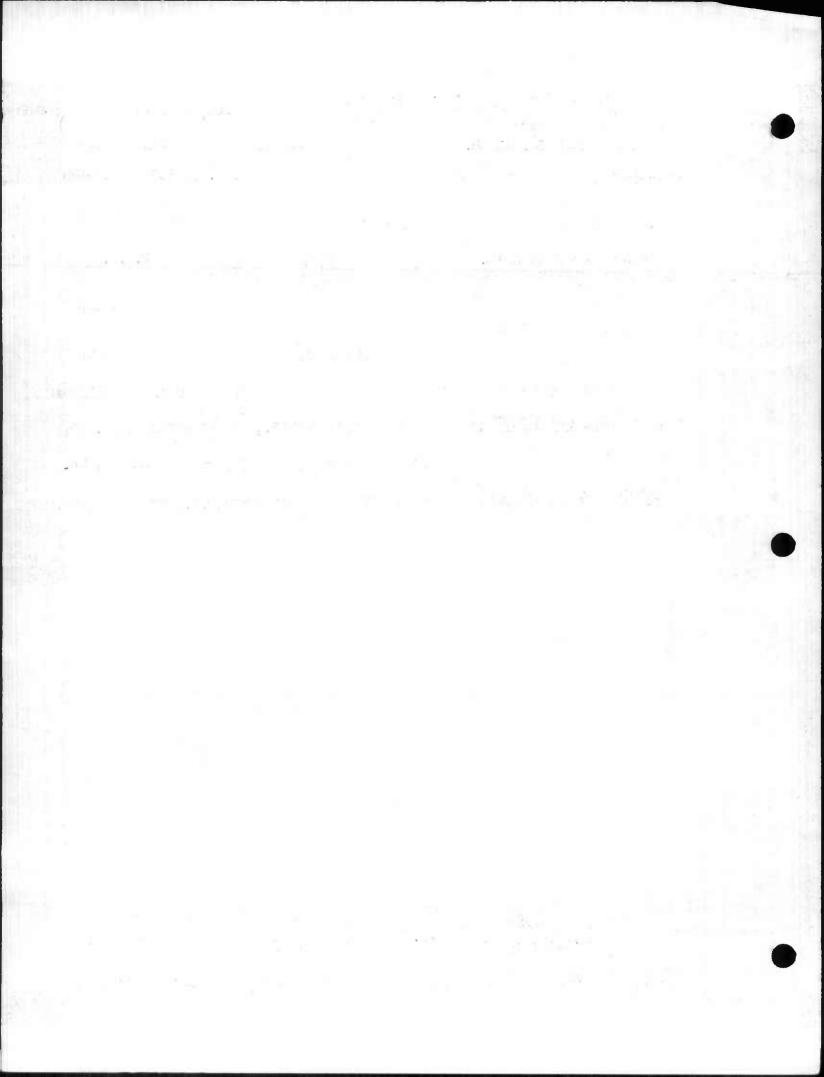
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State of Maryland / Department of Health and Mental Hygiene

						Ce	ertitica	ite or	Death		Reg	. No.					
	Physic /Medi		1. Decedent's Name (First, M	Idle, Last)	M.C	ARR	巨	4		Mont	of Death	, ^{Dey} 1998	Year	3. Time of Death 4:00 AM			
	Examir	ner	4a. Facility Name (If not institu Mariner Hea 14200 L			aurel			4b. City, Town	n, <i>or</i> Location of EL	Deeth	4c. County		RGES			
	Funeral Director		5. Social Security Number 424-07-6067	6. Sex 1 ☐ M 2 🔀		rs. last birthde Yrs.	y) If Und Month	er 1 Yeer s Deys	If Under 24 Hours	Min. 8. Dete	of Birth th, Day, Y	(ear) 1905	9. Birthpled Country ALAF	ce (State or Foreign X) BAMA			
	within 72 hours efter death with the Maryland ene. than "natural", or flems 23s or 28s-f show he Modical Examinet must be nothed at	ō	Usuel Residence of Decedent 10a. Stete 10b. Cou			City, Town or							100	d. Inside City Limits 1 Yes 2 □ No			
	the h	Director	MD. PRIN	CE GEORG	ES	اسلا	UREL	ip Code			104	Citizen of	What Country	35			
	With Man	ā		REL PARK	DD.		101. 2		10.57		105			/ '			
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0	r her	FL	1 Never Merried 2 N	lerried 1 🗆	ed Forces? Yes 2 🗓 No		if Yes, sp	ecify Cube	an, Mexican, F	Puerto Rican, et	c.)		ck, White, etc				
02	al', o	by	3 ☐ Widowed 4 ☐ Divor	ed If Ye	s, Give r or Detes:		1∐ Yes	2 💢 No	Specify:			Specif	WHI?	02			
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121	Man.	d d	Elementery/Secondary (0-1		ege (1-4or 5+)	life.											
	filed with Hygiene. other than		17. Father's Neme (First, Midd	lo Lact)			Н	OMEMA		Neme (First, M	Aiddle 14e		T HON	Æ			
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Maryland	2 should be filed within and Mental Hygiene. Is marked other than surmetic avent, an M.	10	19e. Informent's Neme/Releti	HOUSTOI			ilina Addra	ec (Street	and Alumbar	RILL		MAGIE WILLIGHAM mber, City or Town, Stete, Zip Code)					
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9	0 0		1 ☐ Burial 2 ② Cremetic 4 ☐ Donetion 5 ☐ Other		from Stete	CHAMBE			,	6/26/	00	RTVEE	DALE,	MD			
Baitimore,	그는무슨		21. Signeture of Funeral Serv						ss of Fecility	10/20/	90	7 (T A T)T	وعسمه	rin.			
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Vital	ysician: The	Be	25. Was case referred to med examiner?					Tall!	A	Deeth (Check	only one)						
of	5 00	은	1 Yes 2 No	Hospitel:		☐ ER/Outpati			4 Mursi	ing Home 5 🗆							
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Division	or Attano effer deetl Director: In by the	Certification:	3 Suicide 6 □ Cou		Plece of Injury - At building, etc. (Spe		M street, fecto		Yes 2 No	28f. Loca	tion (Stre or Town,	et end Numi Stete)	per or Rural F	Route Number,			
	Hospital 24 hours Funeral stely filled	edical	29e. Certifier 1 Certification (Check only one)	ying Physician: To al Examiner: On t	o the best of my k the basis of exami menner steted.	nowledge, dea netion and/or l	th occurre	d at the tin	ne, dete and p plnion, deeth	place, end due to occurred et the	o the cau time, det	se(s) and m e and pleca,	enner as stet and due to th	ed. he cause(s)			
	To the within 2 To the comple	Mec	29b. Signeture and title of cent	M-7	ind/or Investigation, in my opinion, deeth occurred et the time, dete and pleca, and due to the cause(s) 29c. License number 29d. Dete signed (Month, Day, Year) 6 23 96												
			30. Neme end address of pers	on who completed	cause of deeth (It	em 23a) (Type	Print)	- fre	OR 2	N SH	- 2	8 1	Au RG	amh			
	Sta	ite	31. Date filed (Month, Day, Ye	91)	32. Registrer's Sig	neture	. 0	-00	•	* 1			10 1-10	20708			

Registrar

JUN 2 9 1998



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			State of Mary		epartment Certificate				giene 9 (3 2	21578	
		a (First, Middla, Las	1)			-		2. Data of Dec	ath		3. Time of Death	
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Examine	4 a Cantilla Mana //	f not Institution, giva	street and number)	11		4	b. City, Town, or L			of Death		
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Funeral	5. Social Security N	11	TM 21XF	yrs. last birti	hday) If Undar 1 Months	Days Days	If Undar 24 Hrs. Hours Min.	(Month, Da		9. Birthp	laca (Stata or Foreign	
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/land	10a. Stata	10b. County	10	c. City, Town	or Location					1	0d. Inside City Limits	
Mar	Maryland	Montgo	merv			В	ethesda				1 ☐ Yas 2 💢 No	
72 hours after death with the Maryland natural; or items 23s or 25s-f show sites Examiner must be nedfied at	Maryland 10e. Street and Nur				10f. Zip (10g. Citizen of V	What Cour	ntry?	
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should be nd Mental marked o		Giu	seppe Bucch	eri				Maria	Amato			
2 sho		ame/Ralationship (T	ype, Print)				and Number or Ru					
and Health m 27	Julia B. Rashti/Daughter 4990 Sentinel Drive #403 Bethesda, 20a. Mathod of Disposition 20b. Place of Disposition (Nama of Data 20c. Location 20c. Locat											
Pages hent of H	1⊠ Burlal 2 □ Cramation 3 □ Ramoval from Stata camatary, cramatory or other placa) June 27,1998										wn, Stata	
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sian a	Sequantially list cor if any, laading to im causa. Entar Unda Causa (Disaasa or	nmadiata irlylng injury										
cate be ohysicia the bur	rasulting in daath) L		Dua	to (or as a co	onsaquanca of):				1,745		41 8 TO 1	
ding p		L	d									
attending pl												
v requires that the death certific been signed by the attending p should be deteched for use as	Part II. Other signifi	lcant conditions co	ntributing to death but no	ot rasulting In	tha undarlying ca	usa giv	an in Part I.				the cause of death?	
that hed b dete								10	Yes 2 X No	3 Pro	bably 4 Unknown	
n sign	2							24a. Was	an autopsy	24b. W	ara autopsy findings ailable prior to	
law rec								peno	med?	co	mplation of cause daath?	
cartificate has been sirector, page 2 should	[1					10	as 2 No		☐Yas 2☐No	
artifical	25. Was casa rafari	red to medical					26. Placa of Dea	ath (Check only o	na)	1		
Attending Physician: or death. ector: After this cartific by the funeral director,	1 ☐ Yas 2 📉	NO			patient 3 DO		4 LI Nursing n	oma 5 🕅 Rasio	danca 6 Oth	ar (Specif	y)	
frer th	27. Mannar of Daatt	h 5 ☐ Panding								red		
tendi leath. tor: A the fu	2 ☐ Accidant 3 ☐ Suicida	Invastigation 6 Could not be			М		Yas 2 □ No	00/ 1/ //	24 - 4		15-1-1-1-	
o # 5 =	determined 288, Place of Injury - At nome, farm, street, factory, office							City or Tox	vn, Stata)	er or Mure	al Routa Number,	
ours ours leral lilled	29a. Cartifliar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.										lated.	
within 24 hours To the Funeral completely filled	(Check only one)		iner: On the basis of axa	mination and								
To the To the complete the comp	29b. Signatura	itla of certifiar			29c.	Licans	a number		29d. Data signe	d (Month,	Day, Year)	
1	D 05246 June 25, 1998								998			
5	30. Nama and addre	ass of parson who c	omplated causa of daath	(Itam 23a) (Typa, Print)		0,5270		June 2	, 1		
	T	T7 T74 J 1	da. M.D. S	401 II	- A A -		ON LI L	Inchinat	on D C	200	15_2000	

State Registrar

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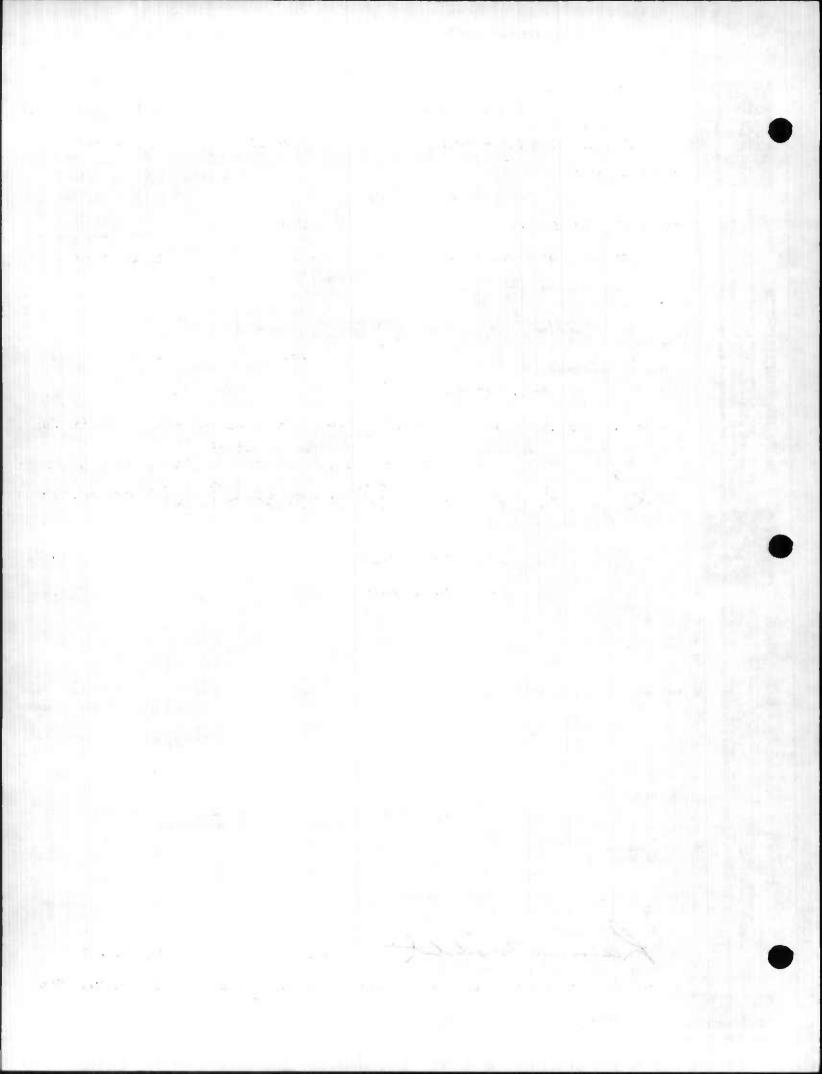
31. Data filed (Month, Day, Year)

32. Ragistrar's Signatura gitia Davidson-Randall

DHMH 16 Ray 6/95

Baltimore, Maryland 21215-0020

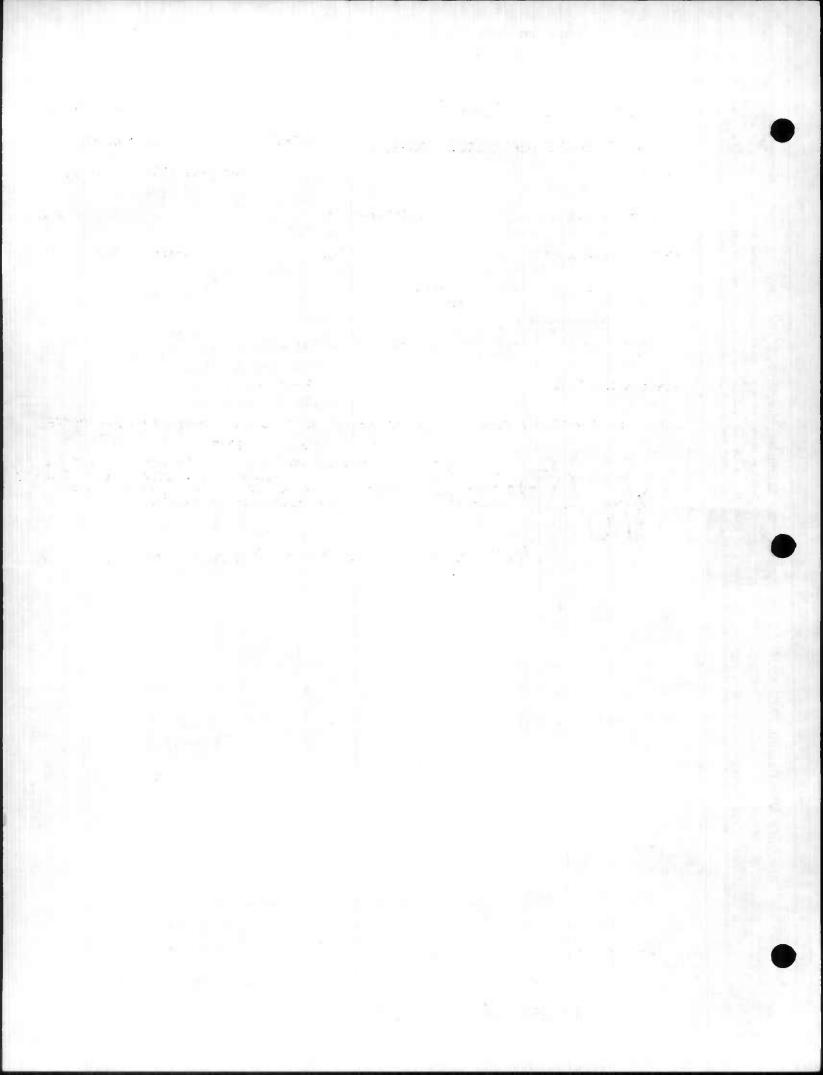
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 12. Date of Death

				,		ificate			Mornar 119	Reg. No.	5 2	15/	9
Physicia: /Medica	in	1. Decedent's Name (First, Middle, L.		1211	aro				2. Date of De Month	ath Day	Yaar GGS	3. Tima of Do	eath
Examine		4a Facility Name (If not institution, gi	ve street end number)						Location of Deat	100			
Funeral Director		SHADY GROVI 5. Social Security Number 6. 053-16-8226 Usual Residence of Decedent	AND ADDE	ST H (In yrs. la	OSPIT st birthday) Yrs.	A T. If Under 1 Months	Year I	OCKVIL TUnder 24 Hrs Hours Min.	8. Date of Bir			ERY lace (State or F try) taly	Foraign
Pue & m	-	10a. State 10b. County		10c. City,	Town or Loc	ation					10	Od. Inside City	Limits
Many	tor	Maryland Montgom	ery		Gaith	ersbu	rg					1 Yas 2	No Do
ith with the	0	10e. Street and Number 18700 Severn Road	d			10f. Zip C	0879			10g. Citizen of V			
15-0020 72 hours after death with the Marylend "naturel", or frems 23s or 28s-f show edical Exartiner mant be notified at	by Fur	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ⊠ Yes 2 □ N If Yas, Giva Yaar or Datas: W	o Worl	Ld 1	as Deceda Yas, specif □ Yas 2[anic Origin? (S Mexican, Puer Specify:	Specify Yas or No to Rican, etc.)	Specify	e - Amaric ck, White, o	etc.	
T c ' iii '	Completed	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12)	Education rade completed) College (1-4or 5-	+)	16a. Decede (Give k life. D Dire	nt's Usual ind of work O NOT use C TO T	Occupation done during retired) of Mu	on ing most of wo ilti Me	rking dia	16b. Kind of Bi Federa Govern	1	iustry	
ind 2 he filed hal Hygi d other event, t	Be Co	17. Father's Name (First, Middle, Las					18	3. Mother's Na	me (First, Middle				
yland 212 ould be filed withi Mental Hygiens. riked other than aftic event, fre. II	0	Francis Cavallar	0				I	Emma B	inni				
Maryla 2 should and Men ie marke eumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address ((Street end	Number or R	ural Route Numb	er, City or Town,	State, Zip	Code)	
a gara	1	Joanna G. Cavalla 20a. Method of Disposition 1⊠Burial 2 □ Cramation 3			nce of Dispos metery, crem	tion (Neme etory or oth	e of her plece)	July 1		erg, Mar 20c. Location			
Itime it. Pa rtant: njury	-	4 □ Donetion 5 □ Other (Special Signature of Funeral Service Lice		Quan				Cemeter	bert A.	Triangl			
Baltimore permit. Pages 1 Department of H Important: If the any injury or or		23a. Ports. Enthrithe distasse, or con- about proper failure. List only	LUMBO	689	Ro	ckvil ockvi	le, 1	Inc. 30 Maryla	0 West 1 and 20850	lontgome 0-2805			ome
Physician /Medical Examiner	H	immedi	a AWTE	Due to (or a	SLIOR as a consequ		STEP	uce 1	Myucseo	a lar	echin	Onset and De	
68 / 60, ifficate be axecuted g physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events	c	Due to (or e	es e consequ	ence of):							
587 tifficate ng phys as the	8	resulting in death) Last	d	Oue to (or a	as a consequ	ence of):					1		
deeth deeth ed for ed for	sicia	Part II. Other significant conditions	contributing to death bu	t not result	ting In the un	derlying cau	use given	In Part I.	23b. Did	tobacco uae co	ntributa to	the cause of	death?
S, F.O. BOX as that the deeth cer igned by the ettendir be detached for use	by Physician/M	LUNG CANCER,	ABOMINAL	_ Aor	27K	MENE	2752		10	Yes 2□ No	3 Prot	bably 4 X Ur	nknow
VItal HECOTOS, P.O. BOX stellar: The law requires that the deeth cercardicate has been signed by the ettendiriector, page 2 should be detached for use	Completed								24a. Was perfo	an autopsy ormed?	ava	ere autopsy find allable prior to mpletion of cau death?	
		OF Manager referred to medical								Yes 2 No	1	Yes 2□ N	10
ysician: ysician: is cartific director,	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2□ E	R/Outpatient	3□ DOA	Other		ath (Check only of the sound of		er (Snecih	v)	
VISION OT VITA Attending Physician: If death. Sector: After this cartific by the funeral director,	- -	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Dey		28b. Time of Injury		c. Injury at Work?		_	how injury occur		,	
= x2=c	Certification:	3 Suicide 6 Could not l	28e. Plece of Inju building, etc.	ry - At hom (Specify)	ne, farm, stre	et, factory,	office			Street and Numb wn, Stete)	er or Rure	I Route Numbe	er,
To the Hospital continues at To the Funeral D completely filled i		29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner stal	exeminetic	ledge, death on and/or inve	occurred at estigation, le	t the time, In my opini	date end pleci ion, deeth occi	e, and due to the urred et the time,	cause(s) end made, date end place,	and due to	ated. the cause(s)	
omple	_	29b. Signatura and title of certifier	and mainter state			29c.	License n	umber		29d. Date signe	d (Month,	Day, Year)	
10+1		POWE -				De	42110			JUNE 2	9.19	98	
J		30. Name and elimss of person who			23a) (Type, F	rint)	, R	OCKIALI	E. mae	YLAND.	20850	2	
State	e	31. Date filed (Month, Dey, Year)	32. Registra										

DHMH 16 Ray 6/95



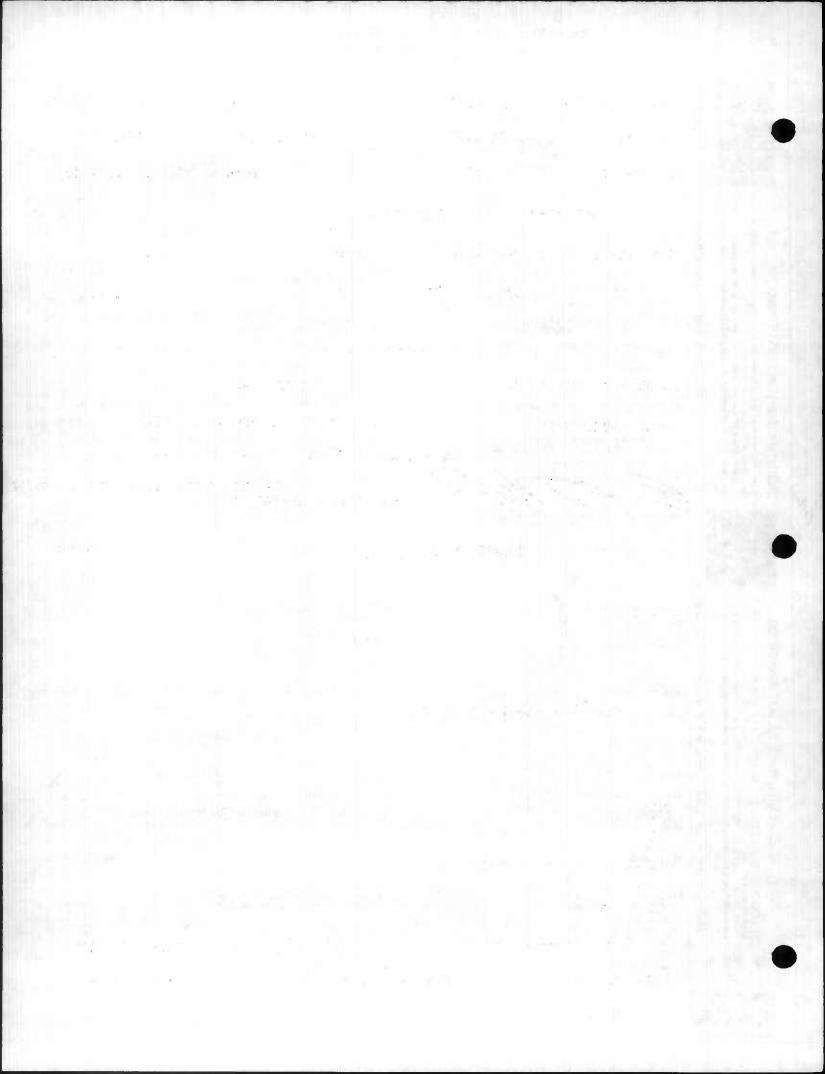
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Daath 3. Time of Death Month **Physician** WILMER PAT CHAPMAN 0200 JUNE NY /Medical 4e, Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 415 SIWOR SOUNG AVENUE SILUGE SPRING montenent | If Undar 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplece (State (Month, Day, Year) | 0 Ctober 23,1919 | Virginia 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1∰M 2□F Months 579-18-4934 78 Yrs. Director Usual Rasidance of Decedant permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exert we must be not if a done. 10e Stete 10b. County 10c. City, Town or Location 10d. Insida City Limita MD MONTGOMERY SILVER SPRING 1 Yas 2 No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 415 SILVER SPRING AVE. #204 20910 USA Funeral 14. Race - American Indian, 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxicen, Puerto Rican, atc.) Black, Whita, atc. 1 ∏ Yas 2 □ No 1944 If Wes, Giva Yaer or Dates: 1946 1 ☐ Nevar Married 2 ☐ Married 1□ Yes 2th No Specify: WHITE Baltimore, Maryland 21215-0020 Specify þ 3 Widowed 4 □ Divorced Completed 18a. Decedant's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) SERVICE STAFF WASHINGTON GAS 18. Mothar's Nama (First, Middla, Maidan Sumama) 17 Fathar's Nema (First Middle Last) WILMER RAY CHAPMAN SR. EFFIE FOX 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. informant's Name/Ralationship (Type, Print) 90713 5330 STEVELY AVE. LAKEWOOD, CA GARY CHAPMAN (SON) 20b. Place of Disposition (Name of cemetery, crametery or other place)
CEDAR HILL CEMETERY 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1/□ Buriel 2 □ Cremetion 3 □ Removal from Stata
4 □ Donation 5 □ Other (Specify) 6-29-98 SUITLAND, MD 21. Signature of Fuheral Service Licensee 22. Name end Address of Facility HINES RINALDI 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Intervel Batween Onsat and Death **Physician** Immadiata Causa (Final disaasa or condition rasulting in daath) DIARRES MEWILL /Medical MONTHS Examiner Dua to (or as a consequance of) Examiner death certificate be executed physician and the buriel-trans Sequantially list conditions, if any, leading to Immadiete causa. Enter Underlying Causa (Disaasa or Injury that Initiated evants rasulting in daath) Last Dua to (or as a consequanca of): P.O. Box 68760, Physician/Medical Dua to (or es e consequence of) S 189 23b. Did tobacco use contribute to the causs of death? Part ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. HOART FAILURE DILESDACT 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? ate has t 1 Yas 2 No 1 Yas 2 No certificate or Attending Physician: funeral director, 25. Was case raferred to medical examiner? 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 12 Yas 2□ No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Data of Injury (Month, Day Year) 27. Manner of Daath 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding after death. Director: Aft 1 ☐ Yas 2 ☐ No 2 Accidant Invastigation the Funeral Director of the Puneral Director of the Pu 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homleida Hospital 29a. Certifier 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated edical Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. one) within 2 To the 29d. Data signad (Month, Day, Year) 29c. License number 29b. Signat and title of certifier 015236 DME JUNE 24, 1998 Dw. 30. Nama and address of person who completed cause of death (Itam 23a) Type, Print) CACL I MAGGL, IM.O. 11125 ROCKVIUT PIKE, ROCKVIUT, Mb 2085L 31. Data filad (Month, Day, Year) 32, Registrar's Signatura State

gripia Davidson-Randalle

Registrar

JUN 2 9 1998



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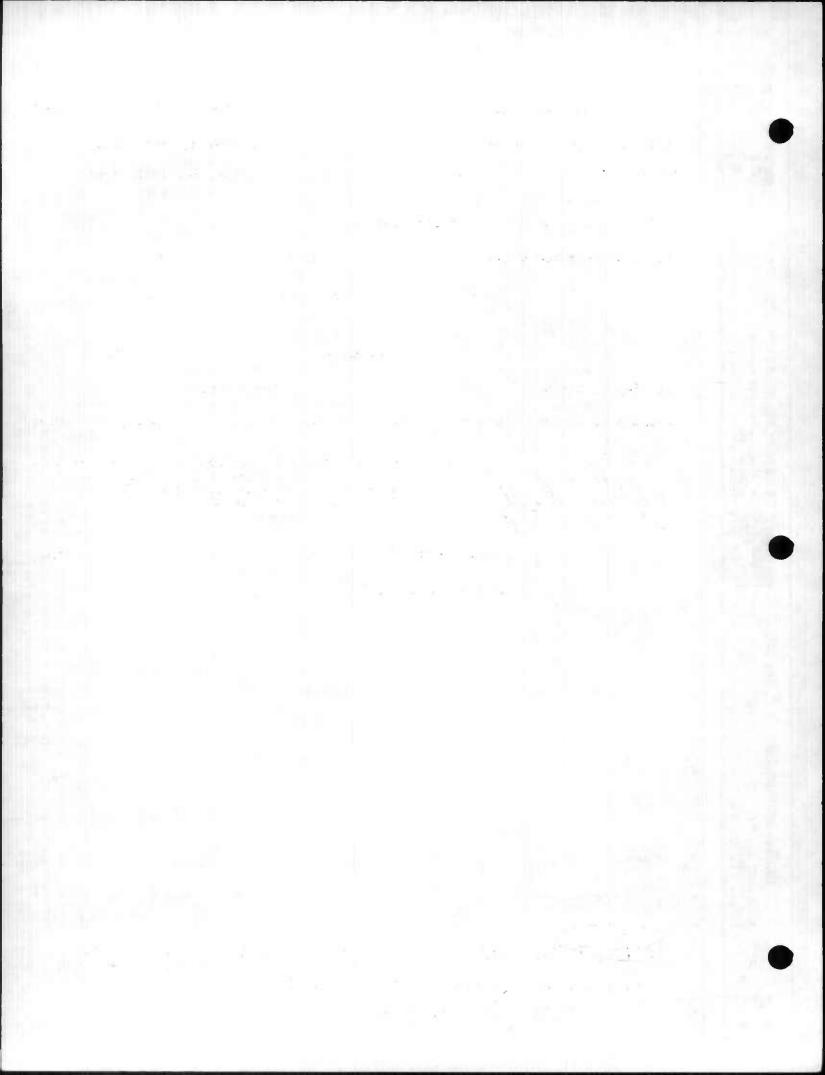
State of Maryland / Depart

artment of Health and Mental H	ygiene	9	8	2	1	En	R
rtificate of Death	Reg. No.			Free	I	U	U

				Certifica	te of	Death		Reg. No.				
Dhysisian	1. Decedent's Name (First, Middle	Last)					2. Date of D	Day	Year	3. Time of Death		
Physician /Medical	Lorraine Elean						June 2	27, 1998		4:18AM		
Examiner	4a Facility Name (If not institution,	give street and number	er)			4b. City, Town,	or Location of Dea	th 4c. County	of Death			
	15416 Bramblew					Silv			gomer			
neral		6. Sex 7 1 ☐ M 2 ☑ F	Age (In yrs. last bii	rthday) If Und Months	er 1 Year Days		Vin. (Month, E	irth (a.y., Year)	9. Birthp	lace (State or Foreign htry)		
ctor	482-18-0776		74	Yrs.			Sept.	18, 1923	Iow	ra		
	Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	n or Location					1	0d. Inside City Limits		
ō	MD Mana		C4 1	. C						1 Yes 2 No		
rector	MD Mont	gomery	Silver	Spring	ip Code			10g. Citizen of	What Cour	ntry?		
Funeral Director		- 1 D		101. 2		0006			771101 000	, .		
era	15416 Bramblew	12. Was Decede	nt Ever in II S	13 Was Dag		0906	2 (Spacify Vac or A	USA 14 Bac	e - Americ	en Indian		
- L	11. Maritel Status 1 □ Never Married 2 ☑ Marrie	Armed Force	\$?	If Yes, sp	ecify Cub	en, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	Bia	ck, White,	etc.		
by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes	2 🖾 No	Specify:		Specif	v: 1	White		
Pa	15. Decedent'			. Decedent's Us	ual Occur	nation		16b. Kind of B				
Completed	(Specify only highest	grade completed)		(Give kind of w	rork done	during most of	working	rob. rand or b	001110001111	outly		
E C	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Secret					NIH			
ŏ	17. Father's Name (First, Middle, L			200200)	18. Mother's	Name (First, Middle					
o Be	Stanley G. Mat						nie Bowe					
F	19a. Informant's Name/Relationsh		191	Mailing Addre	ss (Street		or Rural Route Num		State Zin	Code)		
To Be Co	Richard R. Con						ive, Sil					
	20e. Method of Disposition		20b. Piace o	f Disposition (N	ame of		Date	20c. Location	-			
	1 ☐ Burial 2 ☐ Cremation		te	ry, crematory or					1			
CLI	4 □ Donation 5 □ Other (Sp		Metro	politan			6/29/98 Exercis	Alexandria, Virginia J. Collins Funeral				
S C C	21. Signature of Funerial Service L	icensee		Home,		500 L	Iniversit	v Blvd.	ns ru West	merai		
once.	you /	elle		Silver	Spr	ing, MI	20901					
	23a. Paul. Enter the disease, or o	complication at caused any one cause	sed the death. Do line.	not enter the me	ode of dyi	ng, such es ca	rdiec or respiratory	arrest,		Approximate Interval Between		
an	-50									Onset and Death		
at er	Immediate Cause (Final disease or condition	Metas	tatic Sm	all Bow	el Ca	ancer				5 months		
	resulting in death)	w	Due to (or as a	consequence o	n):							
Inel		_ Bowel	Obstruc	tion					- 1			
Examiner	Sequentially list conditions,	<u></u>	Due to (or as a	consequence o	f):							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury											
/Medical Examir	that initiated events resulting in death) Last	0.	Due to (or as a	consequence of):							
N N		4										
Physician	Part II. Other significant condition	e contributing to death	but not resulting i	n the underlying	cause gi	ven in Part I.	23b. DI	d tobacco use co	intributs to	o the causs of death?		
y Physician							10	Yss 2□ No	3□ Pro	bably 4덫Unknown		
by									T -			
9							24a. Wa	is an autopsy formed?	av	ere eutopsy findings ailebie prior to		
Completed					-		-		of	empletion of cause death?		
mo							10	Yes 25 No	1[□Yes 2√2 No		
To Be Com	25. Was case referred to medical					26. Place of	Death (Check only					
To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2 ER/O	utpatient 3 1	OOA Oti	har	ng Home 5 1 Re		ner /Snacii	(v)		
	27. Manner of Death	28a. Date of I	njury 28b.	Time of	28c. Inju Wo			e how injury occu		,,		
cation	1 Natural 5 Pending 2 Accident Investig		Day Year)	Injury M		irk?]Yes 2∐No						
fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of	Injury - At home, fa	arm, street, facto	ory, office		28f. Location	(Street and Num	ber or Run	al Route Number,		
Certification:	4 Homicide	building,	etc. (Specify)				City or 7	own, State)				
	29a. Certifier 1⊠ Certifying	Physician: To the be	st of my knowledge	e, death occurre	d at the ti	me, date and c	place, and due to th	e cause(s) and m	anner as s	stated.		
edical		xaminer: On the basis	of examination ar									
M	29b. Signature and title of certifies			2	9c. Licen:	se number		29d. Dete signe	ed (Month,	Day, Year)		
							20.					
		US CHAO			Viscon	sty. 38	713.	June 2 exander	29, 1	998		
	30. Name and address of person w	ho completed cause of	f death (Item 23a)	(Type, Print)			AL	exander	unao,	M.D.		
	8901 WISI	CONTINU A	WE, Be	Hurden	MI	20	567.					

Registrar

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Month Veer **Physician** June 25, 1998 2:30 PM Margaret Mary Cooney /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner 7505 Democracy Blvd., #A-138 Bethesda Montgomery If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2MF Months Days Yrs. Director September 1, 1920 Rhode Island 037-16-8441 Usual Residence of Decedent with the Maryland 10d. Inside City Limits r 28a-f show 10e State 10b. County 10c. City. Town or Location 1 Yes 2 No Bethesda Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23s or 7505 Democracy Blvd., #A-138 20817 United States permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Modical Examiner must bonce. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, 12. Was Decedent Ever In U.S. Armed Forces? Biack, White, etc. 1 X Yes 2 No WW II If Yes, Give Yeer or Detes: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Department Eiementary/Secondary (0-12) College (1-4or 5+) Foreign Service Officer of State 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) John Joseph Cooney Bertha Connell 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 198 Queen Anne Club Drive, Stevensville, MD 21666 Bertha C. Garrett/ Sister 20b. Piece of Disposition (Name of cemetery, crematory or other piece) June 30,1998 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 N Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name end Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin 21. Signeture of Funerai Series Lice Bethesda-Chevy Chase, Inc. 7557 Wiscons Avenue, Bethesda, Maryland 20814-3501 1400689 lase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, m. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical 3 Months Congestive Heart Failure Examiner Due to (or es e consequence of): Physician/Medicai Examiner Coronary Artery Disease end -transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician en s the burial-tr Box 68760. Due to (or as e consequença of): use as I ettending p for use as 23b. Did tobacco uss contribute to the cause of death? ed by the deteched o Pert II. Other atgnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 N Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Lung Disease Records, þ 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? Completed peed completion of cause of death? page 2 s 1 ☐ Yes 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 1 Yes 2 No To this 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death Certification: After 1 X Neturei 5 Pending Investigation after death.

Director: Aft
d in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) end menner es stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, dete and piece, end due to the cause(s) end manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and the of certifier 29c. License number 15 D-23556 June 26, 1998

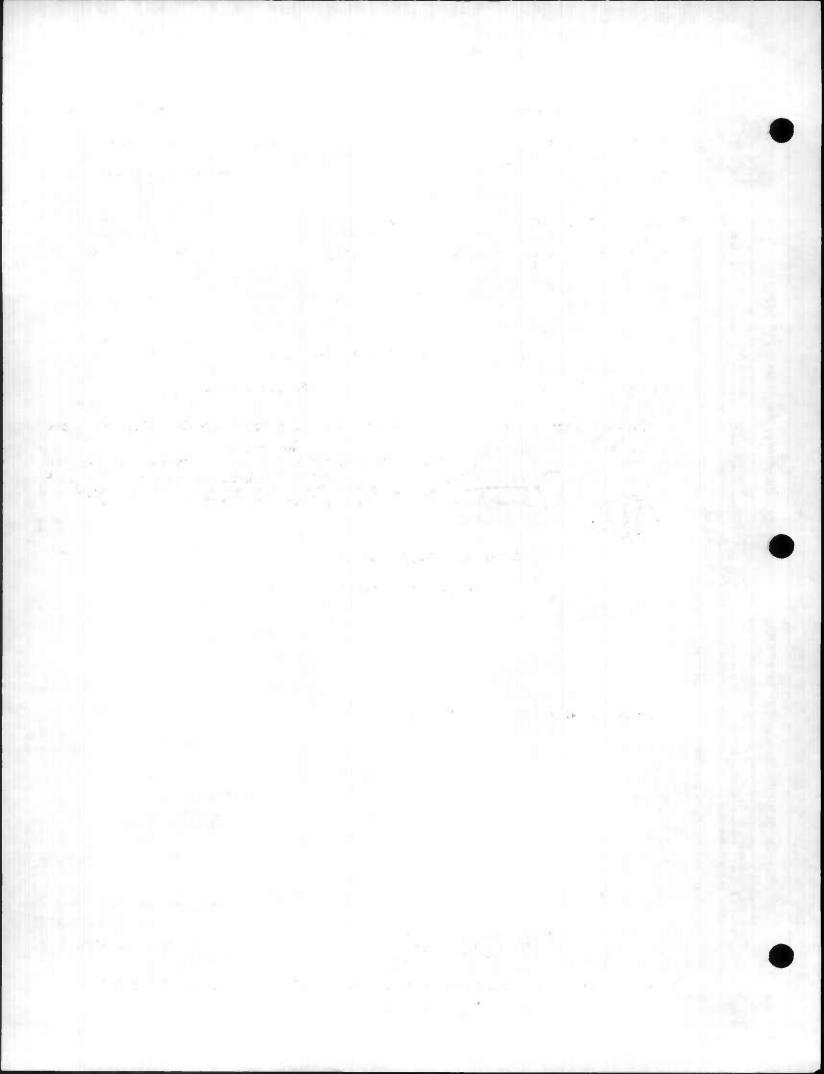
State Registrar

JUL 0 1 1998

Robert H. Blee, M.D.
31. Date filed (Month, Day, Yeer)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

5530 Wisconsin Avenue, #1400, Chevy Chase, MD 20815
32. Recistrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certifica	ate of	Death	F	Reg. No.		
Г	Physici	an	Decedent's Nama (First, Middle, Last)					2. Date of Dea Month	th Day	Year 3.	. Time of Seath
J	/Medi		John Laurence Dill						June 25	, 1998		345
	Examir	ner	4a. Fecility Name (If not institution, give					4b. City, Town, or				
L			Corsica Hills Nurs				1	Centrevi			Anne's	
	Funeral Director		5. Social Security Number 6. Security Number 214-88-9549	7. Age 79 79	(In yrs. last bir	Yrs. Month	der 1 Year Is Days	Hours Min.	8. Date of Birth (Month, De)	N, Year) 18, 1918	9. Birthplace Country) Delawa	(Stete or Foreign
	land w		10a. Stete 10b. County		10c. City, Town	or Location					10d.	Inside City Limits
	Mary H sh	ğ	Maryland Queen Ann	ne's	Cent	revill	0				7	Yes 2 No
	r 28e	Director	10e. Street end Number		OCIT		Zip Code			10g. Citizen of N	What Country?	
	h wit		Maryland Route 213 & A	mstoring Road	1 P.O.Box	c 50	21617		U	nited S	tates	
	deal	Funeral	11. Marital Status	12 Was Decedent Ev	ar in U.S		cedent of h	Hispanic Origin? (S an, Mexican, Puer			ce - American Ir	ndian,
21215-0020	72 hours efter death with the Maryland natural, or flems 23s or 28s-f show deal Examiner must be notified at	þ	Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yes XXNo If Yes, Give Yeer or Dates:			2M No		o Ricen, etc.)	Specify	ck, White, etc. y: White	
5-0	72 hours "natural",	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a.	Decedent's U	suat Occup	petion during most of wo	rkina	16b. Kind of B	usiness/Industr	ry
21	c * 40	npie	Elementary/Secondary (0-12)	College (1-4or 5+)				nai y			
	filed w Hygier ther th		6		Non	e (Di	sable			None (ed)
Maryland	2 should be filed within and Mental Hygiene. Is marked other than burnetic event, tre M	Be	James Leo Dillon						me (First, Middle,		na)	
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Ma	2 8 8 8		19a. Informent's Name/Ralationship (Ty Patricia Marie Gall					end Number or Ri				
e,	s 1 and 2 should be filed within f Health and Mental Hyglene. Item 27 is marked other than other traumatic event, trailed.		20a. Method of Disposition	анау	20b. Place of	Disposition (f y, crametory o	leme of	erce St.	, Centre	20c. Location	Mary Lar	nd 21617
Baltimore,			Buriai 2 Cremation 3 R 4 Donation 5 Other (Specify)	amovel from State	10.17			1				
Ħ	pemit. Page Depertment of Important: If any injury or once.		21. Signature of Funerti Service Licens	11/	Judier	SVIIIe	Ceme	tery - J	une $29, 1$	1998 Sr	llersvill	le, Marylan
Ba	Depenion Depenion Depenion Depenion Depenion Depenies Dep		Whit x	47		Fello	vs, H	elfenbei	n & Newna	am Funez	al Home	, P.A.
			William L. King		00937	3/0 C	pres	s Street	, Milling	gton. M	aryland	21651
	Physician		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	e ceuse on each line				19, 00011 00 001010	or respiratory on	001,	Inte	erval Between set end Death
3	/Medical		Immediata Causa (Final	Pir		1111-					1	month
	Examiner		disease or condition resulting in death)		um O		4).					7007117
_	n #	ner			00 10 (01 20 0 1	011304001100						
	The law requires that the death certificate be executed to hes been signed by the attending physician and page 2 should be deteched for use as the buriel-transit	Examiner	Sequentially list conditions,). — D	ue to (or as e o	consequence	f):					
30,	oe exe cian a vurief-		Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaase or injury								1	
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Box	eath ce attendir for use	Physician/									İ	
o	res thet the de signed by the a be deteched	ysic	Part II. Other significant conditions con	_						/		cause of death?
P.0	thet t ed by dete		ADVANCED	ALZHEI	MERS	DI	SEA!	SE	1 U Y	es 20 No	3 Probably	y 4 🗋 Unknown
of Vital Records,	uires sign	d by		•					24a. Was a	n autonsv	24b. Were a	autopsy findings
00	w requ	Completed							perfor	med?	compla	autopsy findings ble prior to ation of ceuse
Re	The lav ate hes page 2	dwc							400	as 2 No	of deat	
ta		Be C	25. Was cesa rafarred to medicet					Of Disease Day			1 ☐ Ye	s ZIKI NO
<u>></u>	Physician: r this certific rral director,	ToB	avaminer?	lospital:	2 ER/Ou	lpatient 3□	DOA Oth	-	ath (Check only or lome 5 - Reside		ar (Snacihi)	
0	g Ph er thi		27. Manner of Death	28a. Date of injury (Month, Dey		ime of	28c. Injut Wor		28d. Describe h			
ior	Attending I ar death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(MOIRII, Dey	(ear)	njury M		Yes 2 □ No				
Division	or Attendi efter death. Director: A f in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	- At home, fai	m, street, fact	ory, office		28f. Location (S City or Town		per or Rural Ro	ute Number,
Ö	rs eft al Di	Cer		building, old.	opec.iy)				Ony or 70m	n, Stote)		
	To the Hospital or A within 24 hours effer To the Funeral Direct completely filled in b	edicai	(Uneck only 2 Medical Examin	Iclan: To the bast of a	my knowledga, xemination and	daath occurre	ed at the tir	ma, date and place	, and due to the c	ause(s) and ma	anner as stated	l.
	the hin 2 the f	Med	Olley	and manner state	d.							
	To To		29b. Signeture end title of certifier	M. D		2	9c. Licens		2	29d. Dete signe		
			> thu A/				04	1587		01	26/9	8
3		7	30. Nama and addrass of person who co									
		40	Helen Noble, MD,	122 Speer	Koad,	Cheste:	rtown	, MD 21	620			
	Sta Bogistr		III 01'08	32. Registrar	Ani de	Budan						

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State of Maryland / Department of Health and Mental Hygiene 98 91581.

					Ce	ertificate o	f Death			Reg. No.		. 1004
	1. Decedent's Name (Fin	st, Middle, Las	t)			101			2. Dete of Dec	eth	Wasa	3. Time of Death
Physician /Medical	ANTHON'				ris		4h City To	wn orloc	Month 6 eation of Death	Day 24 4c. County	98	2:00 PM
Examiner	111			ber)								
	616 N. Pa			. Age (In yrs	last hirthday	/) If Under 1 Ye		an Ci			ester	iace (State or Foreign
Funeral Director	216-20-282 Usual Residence of Dece	8	X M 2□ F	71	Yrs.	Months Day		Min.	8. Date of Birl (Month, Da 5/22/	y, Year)	Cour	MD
ž ==		County		10c. C	ity, Town or I	ocation					1	0d. Inside City Limits
4 9	MD	Worces	ter		Ocean	City						1X Yes 2□ No
or 28a-f s be notified Director	10e. Street and Number					10f. Zip Code	9			10g. Citizen of	What Cour	ntry?
	616 N. Pa	cific A	V.0			218	2112			USA		
r Hems 23. Wher must Funeral	11. Merital Stetus	cinc /	12. Was Dece	dent Ever in t	J.S. 13	. Was Decedent of If Yes, specify C		igin? (Spe	city Yes or No		ce - Americ	an Indian,
Fur Fur	1 Never Married	2 Married	Armed For	2 □ No		If Yes, specify C	uban, Mexicar	i, Puerto F	Rican, etc.)	Bia	ck, White,	etc.
by	3 ☐ Widowed 4 ☐ [* *	If Yes, Give Year or Da	W	WII	1 ☐ Yes 2X	lo Specify:			Specia	y: wh	ite
Page Page	15. [Decedent's Ed	ucation		16e. Dec	edent's Usual Oc	cupation			16b. Kind of B		
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omp	Elementary/Secondary	(0-12)	College (1-	40r 5+)	Opera	ations D	ivision	Dire	ctor	US G	overr	nment
Be C	17. Father's Name (First,	Middle, Last)								Maiden Sumer	ne)	
S 0	Alexande	r DeSa	nctis				And	rela	Maria -	Trombet	ta	
traumetic To	19a. Informant's Name/F				19b. Mai	ling Address (Str						Code)
	Martha D	oSanct.	ic / Wife		616	N Paci	fic Av	0.	coan C	i+v MD	210	12
other	20a. Method of Disposition		15/_WITE	20b.	Place of Disp	N. Paci	IIC AV	E. UI	Date	20c. Location	- City or To	own, State
any injury or pose.	1 ☐ Buriai 2 ☑ Cre			tate		enlopen		OKY	6/26/98	Frank	ford	DE
n n	4 Donation 5 0					22. Name and Ad		the s				
DOCe	1011	Z .			1			Bu	_	Funera	I Hon	ne
	11.5	X16/2	Julas			108 Willi						
	23e. Perff. Enter the ord shock, or hear fails	List only of	olications that can one cause on e	used the dea ch line.	th. Do not e	nter the mode of	dying, such as	cardiac o	r respiratory a	rrest,	1	Approximete Interval Between
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cal ner	Immediate Ceuse (Final disease or condition		а	1.V1	NG	CAN	CEN				(MONIA.
	resulting In death)				or as e cons						1	
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Examiner	Sequentially list condition	ns,		Due to (or as a cons	equenca of):						
3 =	Sequentially list condition if any, leeding to immedicause. Enter Underlying Cause (Disease or injury		c								i	
s the burial-transit edical Examin	thet initieted events resulting in death) Last			Due to (or as a conse	equence of):						
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be detached for us by Physician/	Part II. Other significant	conditions co	entributing to dea	ath but not re	suiting in the	underlying cause	given In Part	l.	23b. Dld	tobacco uss c	ontributa t	o the cause of death
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page 2 should										an autopsy ormed?	av	ere autopsy findings valleble prior to empletion of cause
ipie										,		death?
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al director, pag: To Be Co	25. Wes case referred to	medical					26. Plac	e of Death	(Check only	one)		
To E	examiner?		Hospital: 1 ☐ Ir	patient 2] ER/Outpeti	ent 3 DOA	Other: 4 N	ursing Hor	ne 5 Nesi	dence 6 🗆 Ot	her (Speci	(y)
, C	27. Manner of Death	70	28e. Dete o	f Injury	28b. Time Injury	of 28c. l	njury at Work?	2	28d. Describe	how injury occu	rred	
Certification:	1 VNatural 5 ☐ 2 ☐ Accident	Pending investigation		i, Doy Todiy	піјату		Yes 2	No				
If C	3 ☐ Sulcide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place	of Injury - At I	nome, farm, s	street, factory, offi	ce	1	28f. Location (ber or Run	al Route Number,
ed	4 El Hollicos		Dullain	g, etc. (apec	<i>"y)</i>				Only or 10	Will Dieto)		
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d E	29b. Signature and title of	of certifier				29c. Lic	ense number			29d. Date sign	ed (Month,	Dey, Year)
completely filled Medical Ce	· Ar)				~	202	00		1/2-	-10 -	
	1000	_					383	22		6/2	3715	3
IAI	30. Name and address or	D-		_ A	m 23e) (Type	e, Print)	2			D =		10000
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State	31. Date filed (Month, Da			gistrar's Sign	nature	Pondelle						
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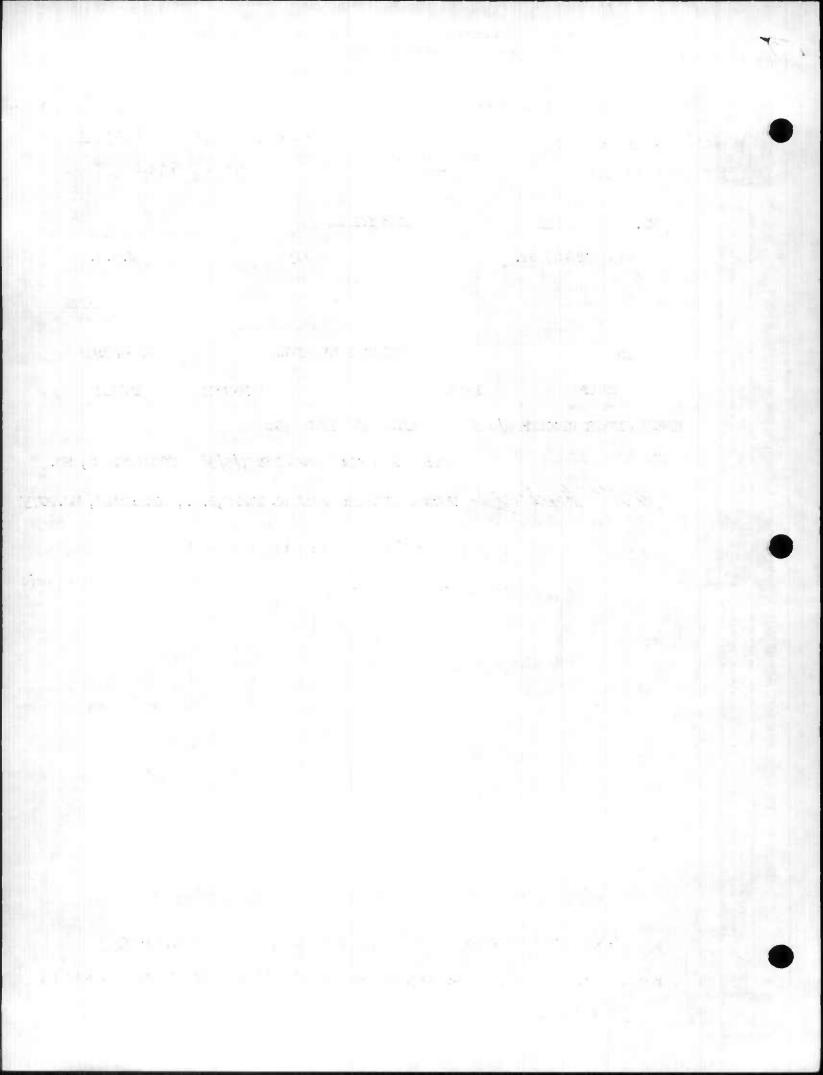
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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Amend #7, 7/2/98, BMW, Montg. Co. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death Dey **Physician** DAVIS. BETTY JUNE 3.30 au L 30 98 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Dale of Birth (Month, Day, Year) CECIL OTSEGO 416 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months 64 - S- Yrs. 236-50-0502 JUNE 21, 1 Director Usual Residence of Decedent the Maryland r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 110 Yes 2 No Directo MD. PERRYVILLE CECIL 10e. Streel and Number 10g. Citizen of Whet Country? 10f. Zlp Code with 1 "natural", or items 23s or edical Examiner must be 416 OTSEGO ST. 21903 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Nems 23, any Injury or other traumatic event, it is Medical Example from Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 M Widowed 4 □ Divorced WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) SCHOOL BUS DRIVER EDUCATION 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THURMAN BAER SAMANTHA HARRIS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) HARRY JOSEPH RIGGLEMAN/SON SAME AS TTEM 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) EPIPHANY CHURCH CEMETERY 7/5/98 FORESTVILLE, MD. 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility unge MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Metastatic Melahoma - liver Immediate Cause (Final disease or condition resulting in deeth) /Medical 3WKs. Examiner Due to (or as a consequence of): 18MOHITS Examiner Melanouna physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lesi Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, that the death certificate be Physician/Medical Due to (or es e consequence of) 88 esn signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings evailable prior to 24e. Was en autopsy performed? Completed completion of ceuse of death? hes page 2 1 Yes 2 No 1 ☐ Yee 2 ☐ No certificate 25. Wes cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetienl 3 | DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No 10 this funeral 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation death. 1 Yes 2 No 2 Accident efter deatl 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e Hospital 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. 29a. Certifier (Check only one) 2 Medical Examinar: On the besis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end menner stated. To the Vithin 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier lunam D32609 MD 6/30/ac 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kamruchin Milham, MD 703 Revolution St. Have De Green nu 21078

State Registrar 31. Date filed (Month, Dey, Yeer)

JUL 0 2 1998

32. Registrar's Signature Randage

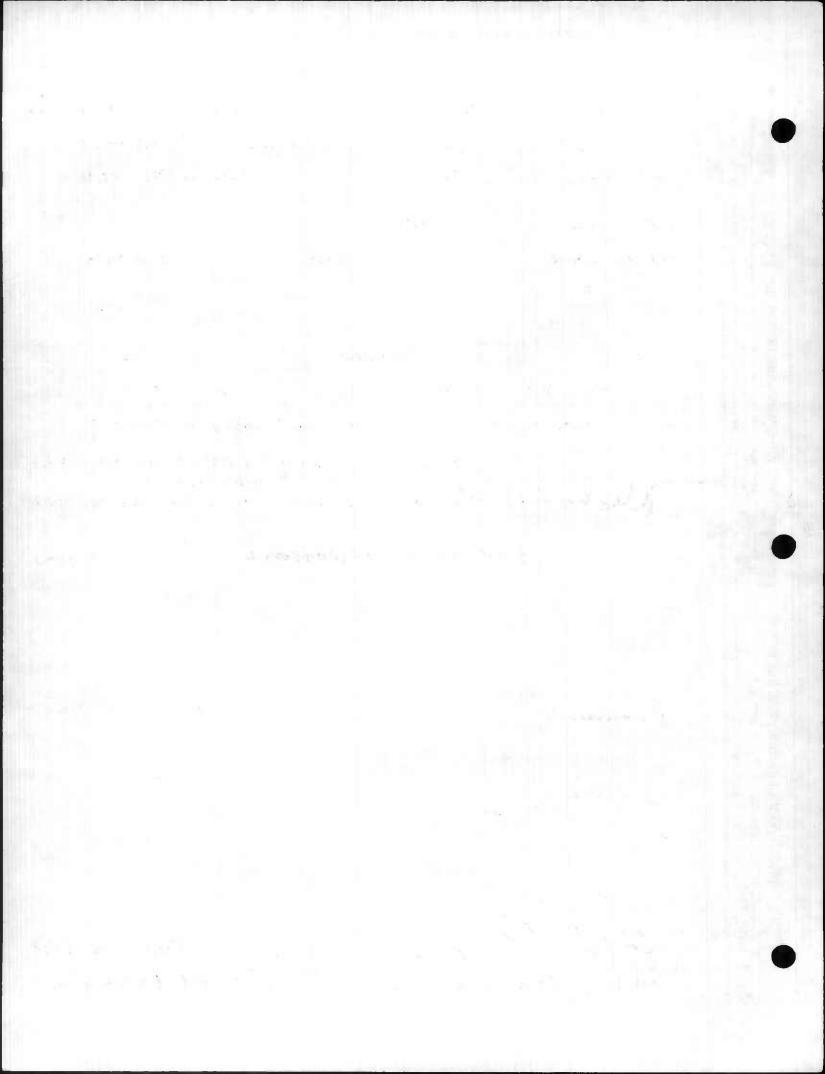


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State of Maryland / Department of Health and Mental Hygiene 98 21586

		Certificate of Death	Reg	. No.	21300
	1. Decedent's Name (First, Middle, Last)	Lam Mark 1	2. Date of Death Month		3. Time of Death
Physician	Alice May Davis			27, 1998	4:00 PM
/Medical Examiner	4e Facility Neme (If not institution, give street and number)	4b. City, Town, or Lo		4c. County of Dea	
Examiner	SHADY GROVE ADVENTIST HOSPITA	T. ROCKVILL	F	MONTGON	(EDV
Funeral	5. Social Security Number 8. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs.		9. Bin	hpiace (State or Foreign
Director	214-30-2422 1 M 2 S F 68 Y	rs. Months Deys Hours Min.	Dec. 11,		ryland
	Usual Residence of Decedent		Dec. II,	IJZJ Ha	Lyland
M 18	10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limit
10	Maryland Montgomery Rock	cville			1 ☐ Yes 2 ₺ No
or 28a-f s be notified Director	10e. Street and Number	10f. Zip Code	100	. Citizen of Whet Co	ountry?
23a or 28a-f show ust be notified at					
23	4804 Bready Road 11. Marital Stetus 12. Was Decedent Ever in U.S.	20853		United St	
Ther must	Armed Forces?	 Wes Decedent of Hispanic Origin? (Spirif Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	Bleck, Whit	
n "natural", or items 2 legical Examiner mu oleted by Funera	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	
d b					nite
et Ba	15. Decedent's Education 16e. I (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	ing	b. Kind of Business	rindustry
nt, the Medical S	Elementary/Secondary (0-12) College (1-4or 5+)			20.00	
Se Co		Homemaker	450 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Home	
Be ve	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	roen Sumame)	
To E	John Henry Kisner		Nellie	Green	
traumatic	19a. informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Run	al Route Number, C	City or Town, State,	Zip Code)
	George H. Davis/Husband 480	4 Bready Road, Rock	ville, Ma	ryland 20	0853
other	20a. Method of Disposition 20b. Placa of	Disposition (Name of crematory or other place)		c. Location - City or	
eny Injury or	1 & Buriel 2 Cremation 3 Li Hemoval from State		/1/1000 0	Silver_Sp	cina MD
2	21. Signeture of Funeral Service Licensee	CO. Nows and Address of Facility			Ing, FiD.
À	01 01	De	Vol Fune	ral Home	
	Michael Cellon	10 East Deer Park D	r., Gaith	nersburg,	
	23a. Pall 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Intervai Between
ician					Onset and Death
ical	tmmediate Cause (Final disease or condition Pulmon Arry	EMPHYSEMA			2 years
iner	resulting in death) a. Due to (or as a c				7-03
9					
ial-transit	Sequentially list conditions. Due to (or as a co	onsequence of):			
T M	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury				
edical	that initiated events	insequence of):			
g physician and as the burial-transit	resulting in deeth) Lest	,			
- 40	d				
for	Dad II Ohbar dadiliana and lalam and	the condendation across of the first factor	noh Dida.t.		to the server of death
be datached for use by Physician/	Part II. Other significant conditions contributing to death but not resulting in	me underlying cause given in Part I.			to the cause of death
Ph data	Puennona		1 DS Yes	2 □ No 3 □ F	robably 4 Unknow
d by			04-14	autono: 24h	Were autopsy findings
, paga 2 should Completed			24a. Was an a		available prior to completion of cause
12 st					of death?
Com			1 ☐ Yes	2100No	1 ☐ Yes 2 ☐ No
0	25. Was case referred to medical	26. Place of Deat	h (Check only one)		
To B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Out	Other:		ca 6 Other (Spe	ecify)
aral o	27. Manner of Death 28a. Date of Injury 28b. Ti	me of 28c. Injury at	28d. Describe how		
tion	1-Matural 5 ☐ Pending (Month, Day Year) In 2 ☐ Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No			
ed in by the funera Certification:	3 Suicide 6 Could not be 28e. Placa of Injury - At home, fan	n, street, factory, office		et and Number or F	ural Route Number,
T.	4 Homicide determined building, etc. (Specify)	of energy mana, M. amag.	City or Town,		
S O					
pletaly fill edical	29a. Certifier (Check only 2☐ Medical Examiner: On the basis of examination and				
completaly filled in Medical Cert	one) and manner stated.				
E S	29b. Signature and title of conflier	29c. License number	290	d. Date signed (Mon	th, Day, Year)
	and Achara	10 D26540		TYNE 2	18 1998
	30. Name and address of person who completed cause of death (Item 23a) (1	ype, Print)			
	Caril. Schoenhens 1	(6220 Freder	of Rd	ba.T	hers bur
Chaha	31 Date filed (Month Day Year) 32a Registrar's Signature		100	04410	>
State egistrar	JUN 3 0 1998 Julia Davidson-Ra	ndell			
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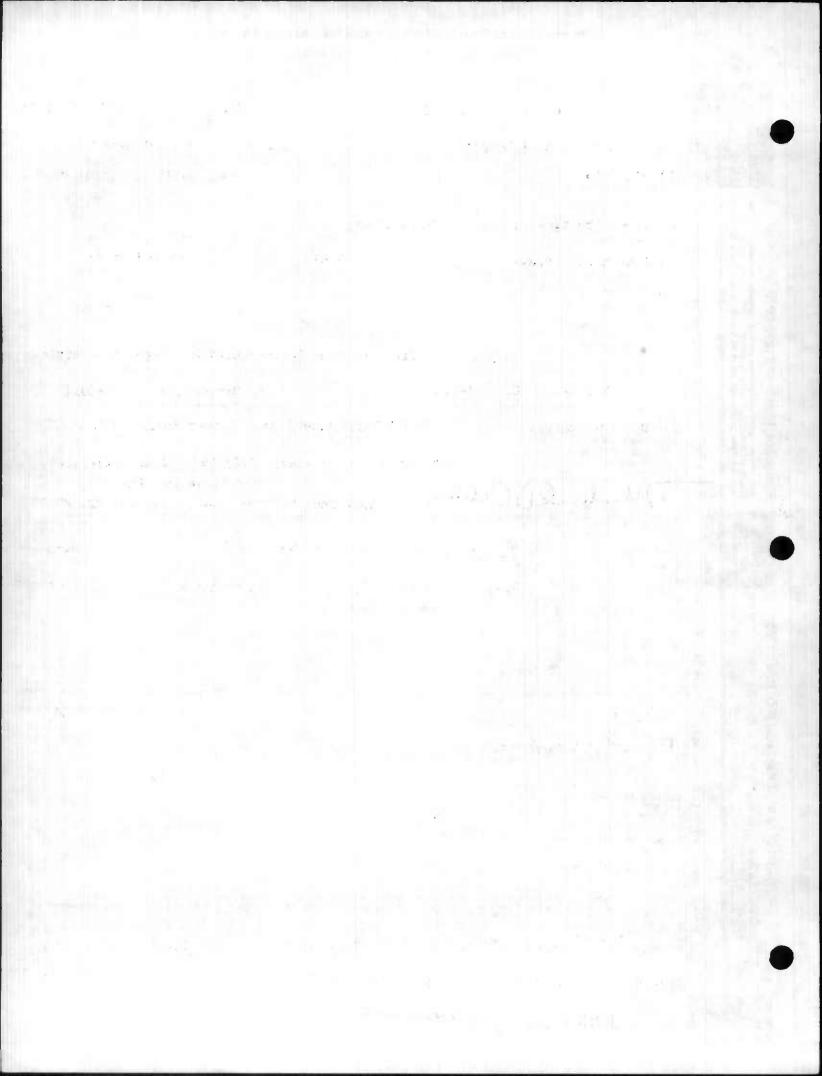


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State of Maryland / Department of Health and Mental Hygiene 98 21587

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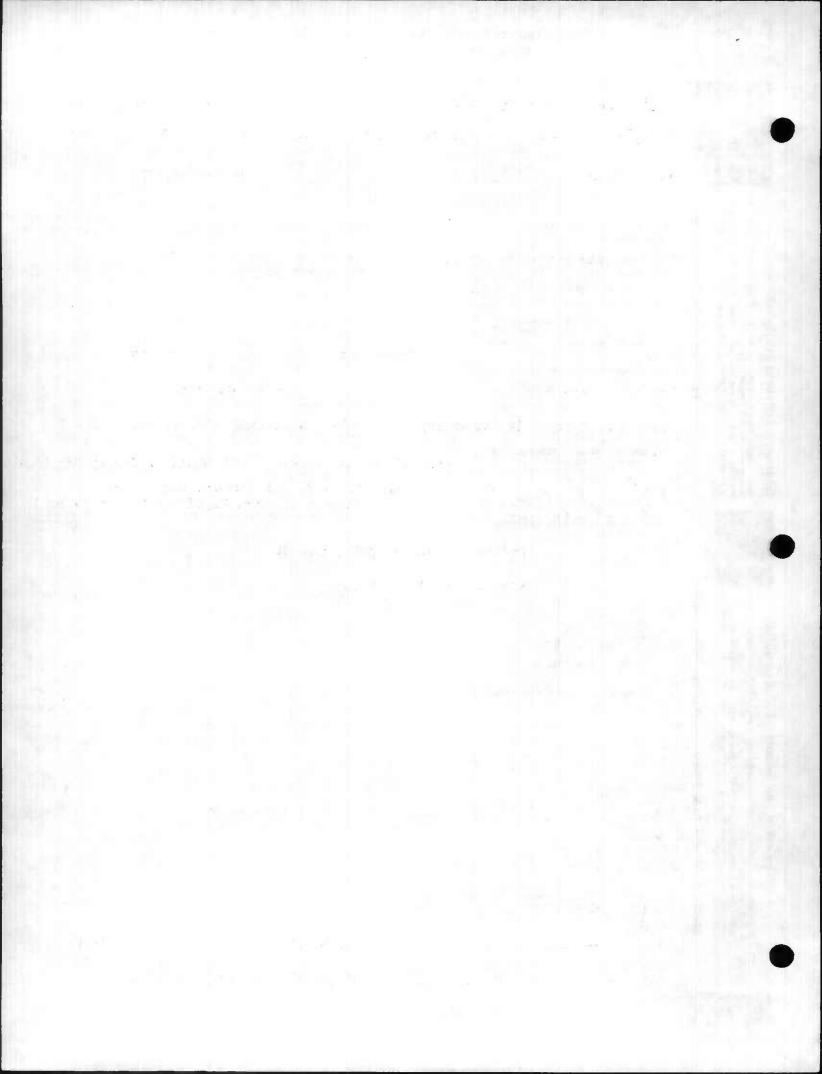
DHMH 16 Rev 6/95



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				Ce	rtificate of	Death		Reg. No.		
	Physician /Medical	F. C. CO13 110		5 0			2. Data of De Month	Day	Year 3. Tima of De	
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	Funeral Director	5. Social Security Number 6. S					lin. (Month, De	rth ey, Year) 14,1912	9. Birthplece (State or F Country) New York	^c oreign
	e Meryland	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome		y, Town or Lo					10d. Inside City I	
	or 28e-fa				10f. Zip Code			10g. Citizen of V	/het Country?	
0.	72 hours after death with the Meryland natural, or flems 23a or 28a-f show pical Evant net must be notified atted by Funeral Director		Drive #1021 12. Wes Decedent Evar in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give		20906 Was Dacedent of I If Yes, specify Cub	Hispenic Origin? en, Mexicen, Pu	(Specify Yas or No earto Rican, etc.)		a - American Indian, k, White, etc.	
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212	filed within Hygiene. ther then ont, it we	Elementery/Secondary (0-12)	College (1-4or 5+)	Hom	emaker			Own Ho	me	
pu	Se set in	17. Father's Neme (First, Middle, Last,)			18. Mother's h	Name (First, Middle	, Malden Surnam	e)	
yla		Ernest Haugh				Marie	e Gunni	ng		
Maryland	2 should and and and and and and and and and an	19e, Informent's Name/Relationship (Rural Route Numb			
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à	nit. Pa artmer ortant: injury	4 Donation 5 Other (Specif	, va		Heaven Co		6/29/98	Silver S	pring, Maryl	and
Ba	Dept.	by quel 1	and a	Fr	ancis J.	Collins	s Funeral			
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U	Physician	shock, or heart failure. List only	one cause on each line.						Onset and De	
H	_/Medical	Immediate Ceuse (Final disease or condition	ANTONIOSCU	moric	AEART () RPASE				
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Ä	The law ate hes page 2						10	Yes 2 No	1□Yes 2	6
ita	ysicien: The securificate director, pag	25 Wes case referred to medical					Death (Check only	one)		
of V	Physician: this certific ral director,			ER/Outpatie	nt 3LI DOA	her: 4 Nursin			ar (Specify)	
sion o	Attending Port death. Sector: After the funeral by the funeral fill cation:	27. Manner of Deeth 1 Neturel 5 Panding 2 Accident investigatio		28b. Time of Injury	Wo	iry et ork?] Yes 2 □ No	28d. Describe	how Injury occur	ed	
Division	re At I her of I her	3 ☐ Suicida 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, st fy)	raet, factory, office			(Street and Numbown, Steta)	per or Rural Routa Numbe	97,
	Hospi 24 hou Funer stely fill	29a. Certifier 1 CertifyIng Pt (Check only a Medical Exar	nysician: To the best of my kno niner: On the basis of examina and manner stated.							
					29c. Licen		ONE		d (Month, Dey, Year)	nl
	12	30. Name and address of person who	completed ceuse of deeth (Item, MO IIIVS Foc	n 23e) (Type,	Print)	ockvil	5 MO	20852		
	State Registrar	31. Dete filed (Month, Day, Year) JUN 2 9 1998	32. Registrar's Signo							
		MXI18 0 1330	A		-					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Date of Deeth **Physician** June 30, Dorothy Mae Doak 2:26pm /Medicai 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan. 10, 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🔽 F Months Deys Hours 84 168-28-6105 Yrs. Director 1914 Pennsylvania Usuel Residence of Decedent filed within 72 hours efter death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Macrical Examiner must be notified at Md. Montgomery Gaithersburg Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10026 Stedwick Rd. #102 20879 United States by Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24 No if Yes, Give Yeer or Dates: 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry lai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Important: If itam 27 is marked other
any injury or other traumatic event 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be William Frank McCully Florence Hanforth 10 19e. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William M. Doak (Son) 19857 Bazzellton Pl. Montgomery Village, Md. 20886 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State July 1. 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Alexandria, Va. 4 ☐ Donetion 5 ☐ Other (Specify) 1998 Metropolitan Crematory 22. Name end Address of Fecility DeVol Funeral Home 21. Signeture of Funeral Service Licens etis 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate intervet Between Onset end Death **Physician** /Medicai Immediete Ceuse (Finei Mikukes Seizure diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner MY POXI a The law requires that the death certificate be executed and the buriel-tren Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, physicien Physician/Medical Due to (or es e consequence of) USB BS attending signed by the at d be deteched for Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings evailable prior to completion of ceuse of death? 24e. Wes en eutopsy performed? peeu has pege 2 After this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No filled in by the funeral 27. Manner of Death Date of tnjury (Month, Dey Year) Certification: 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturei injury death. 1 Yes 2 No 2 Accident after death Director: 3 Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitat o within 24 hours af To the Funeral Di Medicai 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner stated. 29b. Signeture and tales certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D46741 M. O 30, 1998 June

State Registrar 31. Dete filed (Month, Dey, Year) JUL 0 2 1998

Deepak



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Rockville,

Medical Center

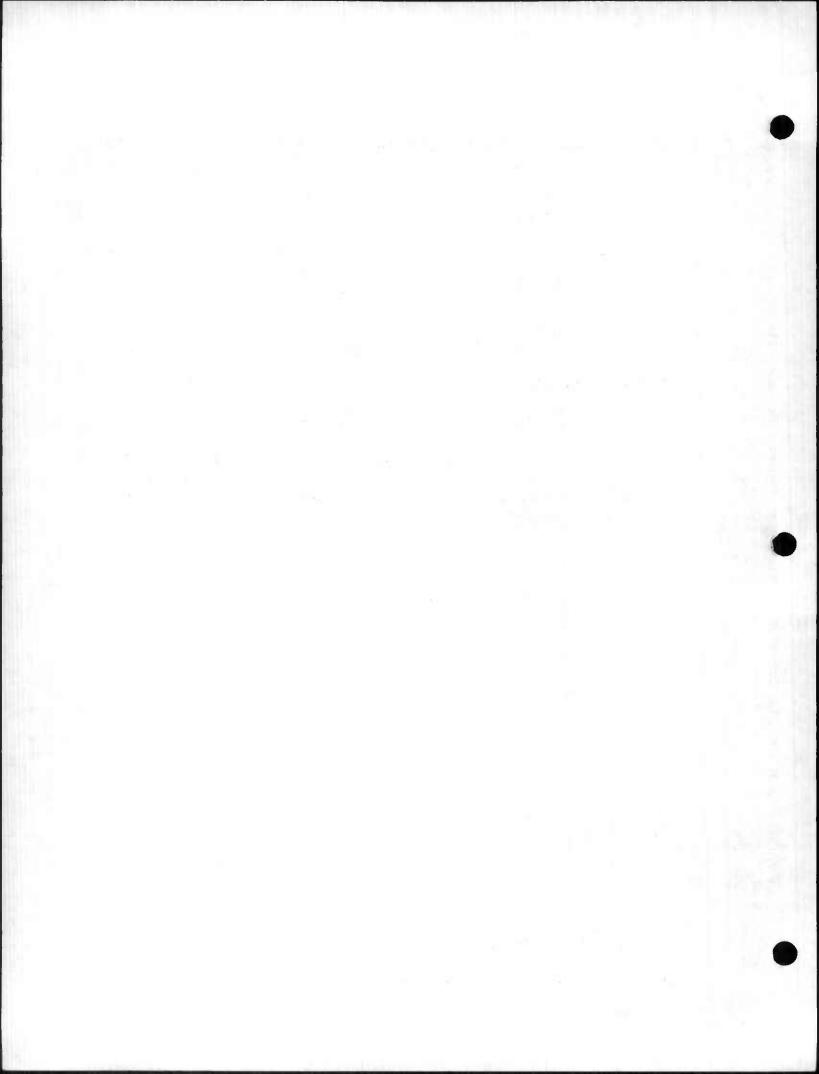
Maryland

Drive

20850

30. Neme and address of person who completed ceuse of death (Item 23a) (Typa, Print)

Bmw



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Ruth D. Donovan June 27, 1998 2:45 A.M. 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring
r | H Undar 24 Hrs. | 8. Date
| Hours | Min. | (Mo Holy Cross Hospital Montgomery 5. Social Sacurity Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foreign Country) Months Days Yrs. 294-14-7771 July 25, 1920 Ohio Usual Rasidence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yas 2 No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 9406 St. Andrew's Way 20901 U. S. A. 11. Marital Status 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No If Yas, Give XX Yaar or Datas: 1 ☐ Yes 2 No Specify: White 3€Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantery/Secondary (0-12) College (1-4or 5+) 4 Years Vice President and Manager 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Edward Richard Deitemeier Emma Christine Stang 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Edward R. Deitemeier, Brother 515 Ethan Allen Avenue, Takoma Park, Maryland 20912 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) July 1, 1998 Brentwood, Maryland Fort Lincoln Cemetery
22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvica Licansas Takoma Funeral Home 254 Carroll Street, N.W., Washington, D.C. 20012 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediata Causa (Final disaasa or condition resulting In death) ESPIRATORY Sequentially list conditions, if any, laading to Immadiata causa. Enter Underlying Cause (Diseasa or Injury that initieled avants rasulting in daath) Last TROKE CHRONIC OBSTRUCTIVE LUNG DISEASE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Wes casa refarred to medical 26. Pleca of Death (Check only one) Other: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 1 Yas 2 No 1 X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Panding Invastigation 1 Natural 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be determined 28e. Plece of Injury - At homa, farm, straet, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 Homicide

Examiner The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760 attending physician To the Hospital or Attending Physician: The law within 24 hours aftar death.

To the Funeral Director: After this certificate has

the burial-transit been signed by should be detac in by the funeral

Physician

/Medical

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Certification:

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Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Haatth and Mental Hygiene. Int: If Item 27 is merked other than "natural", or Items 23s or 28s-1 show

permit, Pages 1 and 2: Department of Haalth ar Important: If Item 27 is any injury or other trausonce.

Physician /Medical

Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

29e. Certifiar Certifying Phyalcian: To the best of my knowledge, deeth occurred at the tima, date and plece, end due to the causa(s) end menner es steted.

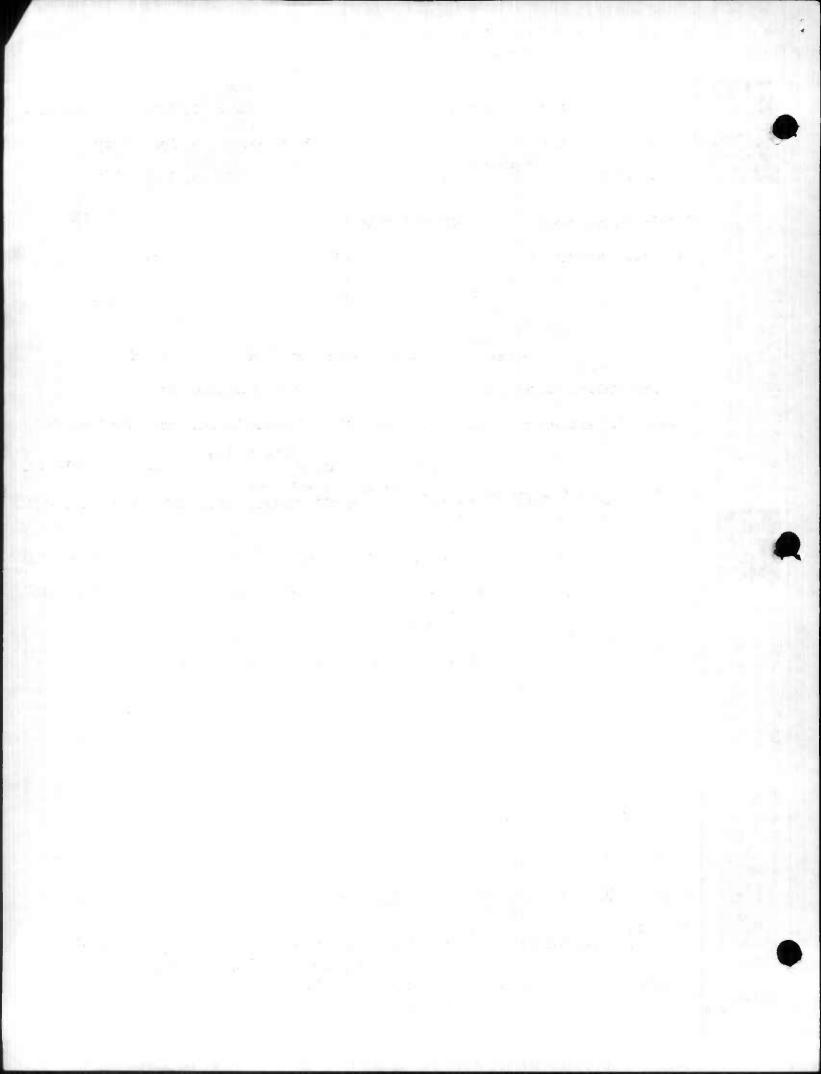
Medical Examiner: On the basis of exeminetion and/or invastigation, in my opinion, deeth occurred at the tima, data and place, and due to the causa(s) and manner stated. (Check only

29b. Signature and title of cartifier PHYSICIAN Shormely AND

29c. Licansa number D40804 29d. Data signed (Month, Day, Year) 06/27/

30. Nema and addrass of person who completed cause of death (Itam 23a) (Type, Print) KEWAL K. SHARMA MD 10620 GEORGIA AVE #114. SILVER SPRING MD-20902

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth 3. Tima of Death HITREIDA VEMBY 1998 4b. City, Town, or Location of Death 4a Fecllity Nema (If not institution, give street end number) 4c. County of Death BALTIMORE 04 BAUTMORE HOSPITAL BALTIMORE 1N4i If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar Birthplace (State of Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Deys 1 □ M 2 X F Months 55 Yrs. 215-44-6241 6 - 19 - 43Maryland Usuei Residance of Dacedan 10c. City, Town or Location 10d. Inside City Limits 10a Stata 10b. County 1 Yes 2 No Dorchester East New Market 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Coda 5804 Depot Road 21631 United States 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian, 12. Wes Decedent Ever in U,S. Armad Forcas? 11. Marital Status Black, Whita, etc. 1 Navar Married 2 Married □Yas 2 No Yes, Giva 1 Yas 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) Elamantary/Sacondery (0-12) Collega (1-4or 5+) 10 Homemaker Own Home 18. Mother's Nama (First, Middla, Malden Sumeme) 17. Fethar's Name (First, Middla, Last) Helen Jones Blackston Harold Jones 19b. Mailing Addrass (Straet end Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) Laura Collins/ daughter 400 Hubbard Ct. Hurlock, MD 21643 20b. Placa of Disposition (Nama of camatery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 X Buriai 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Mt. 7/3 Zion Cemetery East New Market, MD 21. Signatura of Funaral Sarvica Licansaa 22. Nama and Addrass of Fecility Framptom-Hawkins-Eskow Funeral P.O. Box 43 Federalsburg, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Home 21632 PERITONEAL (ALCINO MA 18 months Immediata Ceusa (Final disaasa or condition rasulting in daath) Due to (or es e consequança of) Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Diseasa or Injury that initiated avants resulfing in daath) Lasf Dua to (or as a consaquanca of): Dua to (or es e consequenca of): 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yss 2 No Atel Cardibryopath 24b. Were autopsy findings aveilable prior to 24a. Was en autopsy performed? Ascites completion of cause of deeth? dromphes is 1□ Yas 1 ☐ Yes 2 ☐ No 25. Was casa ratarred to medical axaminar? 26. Plece of Death (Check only one) Hospital: 2 Inpatiant 2 Inpatiant 2 (Month, Day Year) Othar: 4 Nursing Homa 5 Residanca 6 Othar (Specify) 2 ☐ ER/Outpetienf 3 ☐ DOA 27. Menner of Deeth 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of Natural 2 Accidant

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be

permit. Pages 1 end 2 should be filed within 72 hours after t Department of Heelth end Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Iter any Injury or other traumetic event, the Medital Examina-

Baltimore, Maryland 21215-0020

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physician end the burial-transit The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, SB use for ed by the a signed t page 2 certificate

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Hospital

To

Attending Physician: After this funerel death.

Examiner Physician/Medical þ Completed Be Certification: To 24 hours after deaf Funeral Director: 3 filled in

5 Panding

Investigation 6 Could not be datemined

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)

1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

29a. Cartifiar (Check only one) 29b. Signeture end title of cartifiar

3 ☐ Suicida

4 Homicida

Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end mannar as stated.

Msdical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) end mennar stated. 29c. Licansa number

M

RBC 008627R

29d. Data signed (Month, Day, Year) 98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Horoital Balture JINAi

31. Data filed (Month, Day, Yaer)

32. Registrar's Signatura he Davidson-Rand

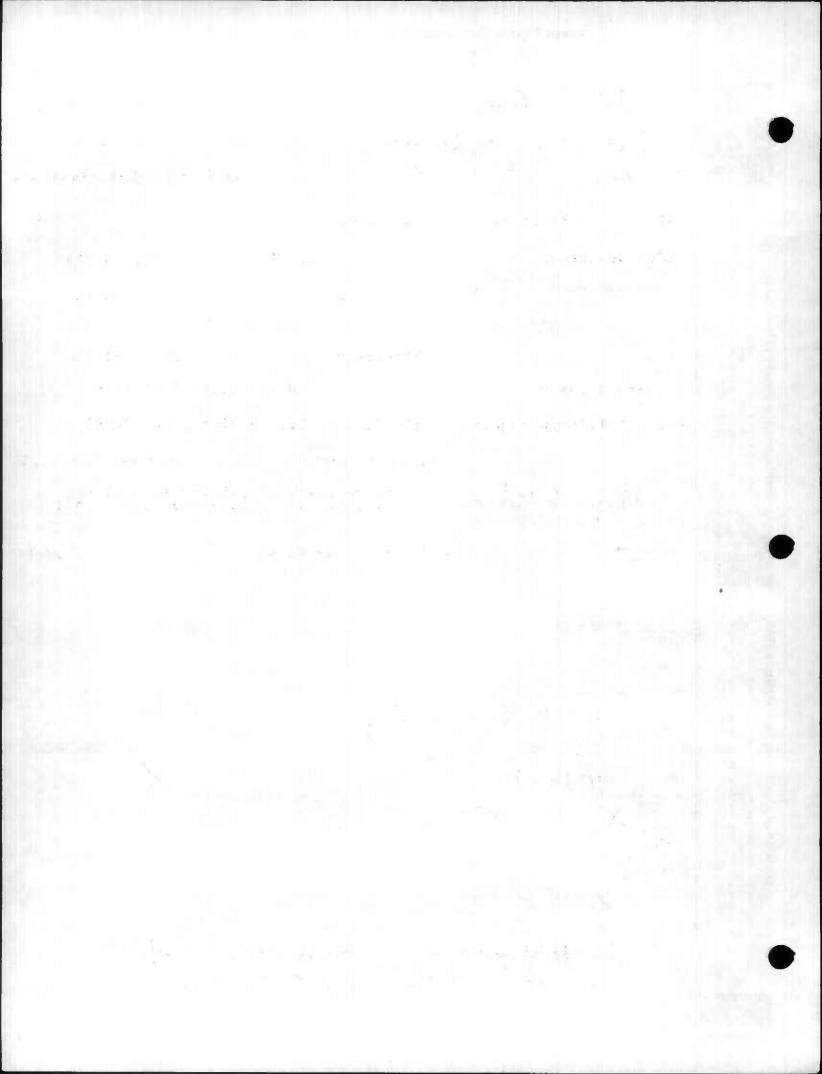
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State Registrar

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U	/Medi		Pearl A. Dyer				June	25 199		1:15 PM
	Examir	ner	4a. Fecility Nama (If not institution, giva street and number)			4b. City, Town, or L		4c. County		
L			13225 Greensboro Road 5. Social Sacurity Number 6. Sex 7. Age (in use fact high days	If Undar 1 Yaar	Greensbor	-	-	line	
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	and and		Usual Rasidence of Decedant 10a. Stata 10b. County 1	0c. City, Town or Loc	ation				10	d. tnside City Limits
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	3a o	Funeral Director	13225 Greensboro Road		2	1639		U.S.A.		
	death	ner	11. Marital Status 12. Was Decedent Eve		as Decedant of I	Hispanic Orlgin? (Sp	ecity Yas or No-	14. Race	- Amarica	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by	1 ☐ Navar Merried 2 ☐ Married 1 ☐ Navar Merried 2 ☐ Married 1 ☐ Yas 2 ☑ No If Yas, Give Year or Datas:		Yas, specify Cub ☐ Yas 2½ No	Specify:	Hican, etc.)	Specify:	k, White, a Wh:	
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21	a. a	npie	(Specify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+)		O NOT usa ratire		ang			
7	ygien ygien f, tr	ပ္ပ	8th	seams	stress	T		manufac		ıg
and	d oth	Be	17. Fathar's Name (First, Middla, Last)			18. Mothar's Nam	a (First, Middla,	Maiden Sumami	a <i>)</i>	
ž	Mer Merke Marke	1º	Robert Laramore				Cohee I			
Ma	d 2 st h and 7 te n traun		19a. Informant's Name/Ralationship (Type, Print)			t and Number or Rur				
	1 an Healt em 2		Jonna Heacock/ granddaughter 20a. Method of Disposition	3819 20b Place of Dispos	9th Str	eet North	Beach,	Marylan 20c. Location -		
Baltimore,	ages intof		Laboner 2 Liciamation 3 Linemoval from Stata	20b. Place of Dispos cemetery, cram	atory or other pla			200, Location	Only Of 104	m, Stata
	rtani		4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Service Licensaa	Greensbor	O Cemet		6/28	Greensb	oro,	Maryland
Ba	Depar Impor any ir		Much (Flend			Helfenbei O Greensb	n Funera	1 Home,	PA 1639	
,	Physician /Medical Examiner	r	23a. Part 1. Entar tha diseasa, or complications that causad the shock, or heart failura. List only one cause on each line. Immediate Causa (Final disease or condition resulting in death)	phora to (or as a consequ		escular	/	7		Approximata Intarval Between Onsat and Death
Box 68760,	se that the death certificate be executed gred by the attending physician and be detached for use as the burial-transit	Physician/Medical Examiner	if any, laading to immadlata cause. Entar Undarlying Causa (Disaasa or Injury c.	a to (or as a consequ						
	deat	sicia	Part II. Other significant conditions contributing to death but n	ot resulting in tha un	dariying causa gi	ven in Part f.	23b. Did to	obacco use con	tribute to	the cause of death?
P.O.	that the ned by the detach	by Phy					101	'es 2□ No	3 Prob	ably 400nknown
Records,	aw requin	Completed b					24a. Was a parfor		avai	re autopsy findings ilabla prior to aplation of cause eath?
	The ate h	COL					1 🗆 Y	as 2□No	1 🗆	Yes 2 No
Vita	delan: The cartificate	Be	25. Was case referred to medical examinar?			28. Place of Deat	th (Check only or	те)		
	ding Physician: h. After this cartific funeral director,	lon: To	1 Yas 2 No Hospitat 1 Inpatiant 27. Manner of Death 1 Naturat 5 Pending	2 ER/Outpatient 28b. Time of Injury	28c. Inju	ry at ork?	ome 5 Resid 28d. Dascribe h	ence 8 Othe		
Division of	or Attan after deat Director: In by the	Certification:	2 Accident invastigation 3 Suicide 6 Could not be datarmined 28a. Place of Injury building, atc. (c	- At homa, farm, stra Specify)		Yes 2 No	28f. Location (S City or Tow	treat and Numbe n, State)	er or Rural	Route Number,
	To the Hospital within 24 hours and To the Funeral Completely filled	edical Co	29a. Cartifiar (Check only 2 Medicat Examiner: On the basis of ax	a <i>m</i> ination end/or inva	occurred at tha ti	me, data and plece, opinion, death occur	and dua to tha c	ausa(s) and mar late and place, a	nnar as sta ind dua to	ited. tha cause(s)
	within 2 To the comple	Med	one) and mannar stated 29b. Signetura and titla of certifier	1.	29c. Licen	sa number		29d. Date signed	(Month C	Day Year)
	₹ ¥ ₹ 8	13.5	Daniel La		7 ?	127/		/	9-9	5
			20 Name of Street		1)	17/6		0 1	4 /	11629
			30. Name and addrass of person who completed cause of deat	n (Item 23a) (Type, F	IN KO	t 40.	- Do	ita	, ,	350
	Sta	te	31. Data filad (Month, Day, Year) 32. Ragistrar's	Signature	10/10	5 30		mol	<i>U</i>	a
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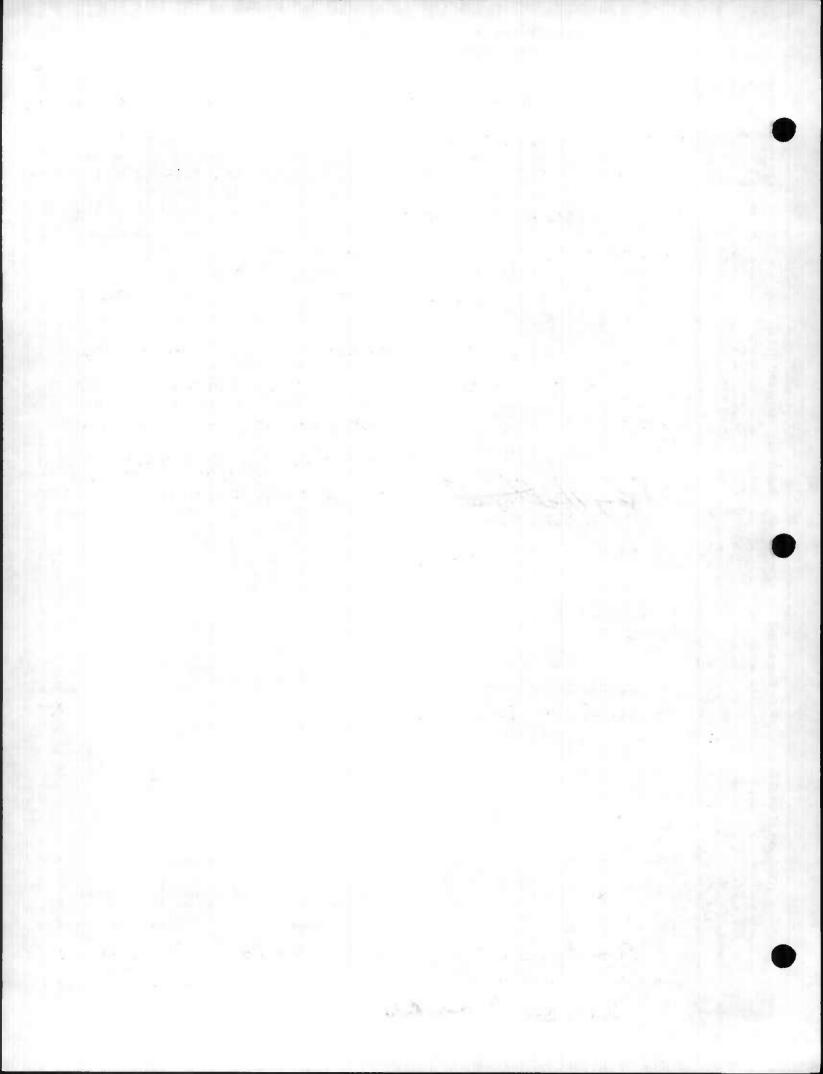
ac il les allas secole la les comment il la secole la vis di and the state of t

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey JUNE 26, 1998 **Physician** DeLois Hartley DeFoe 15:43 · /Medical 4b. City, Town, or Location of Deeth 4e Fecllity Neme (If not institution, give street end number) 4c. County of Death Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL 7. Age (In yrs. last birthday) If Under 1 Yeer Birthplece (State or Foreign Country) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number **Funeral** Months Deys 152 M 2□ F 333-09-6429 84 Director OCT. 6,1913NORTH DAKOTA Usual Residence of Decedent the Maryland 10e. Siete 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or frems 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1X Yes 2 No MD. CARROLL WESTMINSTER Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code with 44 WEBSTER ST. 21157 USA. death permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If fam 27 is marked other the any injury or other traumers. Was Decedeni of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, 11. Marital Status Bleck, While, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: WHITE Yeer or Daies: WW II by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) MANAGER MANUFACTURING 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) HARRY W. DeFOE HELEN EISING 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Retetionship (Type, Print) AGNES DeFOE - WIFE 44 WEBSTER ST., WESTMINSTER, MD. 21157 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1X Buriel 2 ☐ Cremetion 3 ☐ Removei from State MEADOW BRANCH CEM. 6/29/98 WESTMINSTER, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23e. Part1. Enier libe disease, o complice ions thei caused the deeth. Do not enter the mode of dyling, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) 3 days urosepsis Examiner Due to (or es e consequence of): Examiner ician and buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Couse (Diseese or Injury that initioted events resulting in deeth) Lest Due to (or es e consequence of): attending physician requires that the death certificate be rt/ey Physiclar/Medical Due to (or es e consequence of): the 60 use Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. 1 Yss 2 No 3 Probably 4 Unknown Dementia multi-infarct Aq Q 24b. Were eutopsy findings eveileble prior io 24a. Wes en eutopsy Completed completion of ceuse of deeth? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No L C Be 0 Hospital or Attanding Physician: 25. Wes cese referred to medical examiner? 26. Ptece of Deeth (Check only one) Hospitat: 1 19 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 120 1 Yes 2 No 28b. Time of Injury FOE D 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28d. Describe how Injury occurred 28c. Injury et Work? 1 Naturel 5 Pending investigation s efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, sireel, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours Ochpletely fills

| OE7 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner as steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. the state of 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier June Desa mo 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) 200 Memorial Avenue LISA Kim, m. D At Carroll County General Hospital Westminster, MD 21157 31. Dete filed (Month, Day, Year) JUN 2 9 32 Registrar's Signeture State

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Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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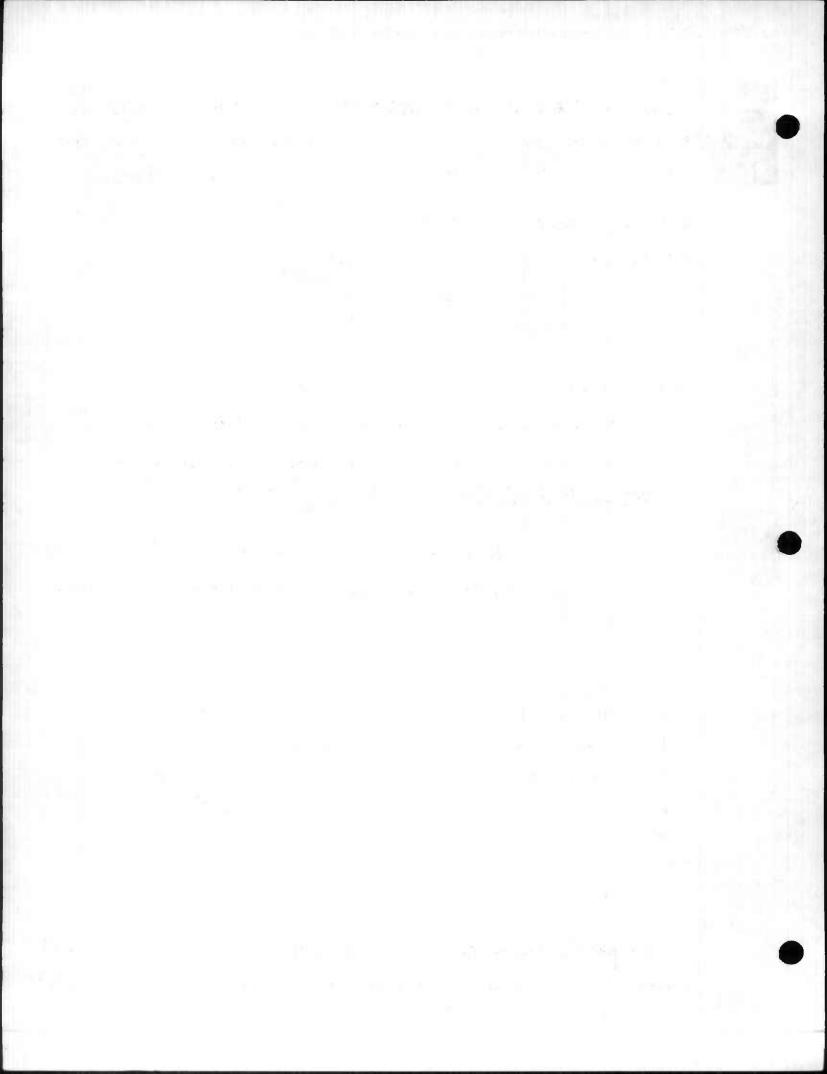
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						Certificate of	oi Death		Reg. No.			
	Physic /Medi			RMO		HENRA		2. Dete of D Month J	Dey 2 (Year 998	3. Time of Death 8:34am	
	Exami	ner	4a. Facility Name (If not institution, g		m <i>ber)</i>		4b. City, Town, o	or Location of Dea	th 4c. County	of Death		
			9412 Horizon Run	Road			Gaithe	ersburg		gomer	у	
	Funeral		Social Security Number 6.	Sex	7. Age (In yrs. lest bir	thdey) If Under 1 Ye Months Da			irth	9. Birthp	lece (Stete or Foreig	
l.	Director		565-16-7122 Usuai Residenca of Decedent	1⊠M 2□F	81	Yrs.	tys Hours W		7, 1916			
	ylan		10a. Stete 10b. County		10c. City, Town	n or Location				10	0d. Inside City Limits	
	be filed within 72 hours efter death with the Maryland nat Hyglene. Id other than "naturel", or items 23e or 28e-f show event, the Modical Exercises must be notified at	Director	Maryland Montgon	nery	Gaith	ersburg	111			1 ☐ Yes 2 ☒ N		
	5 6	Di	10e. Street and Number			10f. Zip Cod	le		10g. Citizen of	What Coun	try?	
	23e		9412 Horizon Run	Road		2087	9		United	d Sta	tes	
	de la	Funeral	11. Maritei Status	12. Wes Dec Armed Fo	edent Ever in U,S.	13. Was Decedent if Yes, specify C	of Hispanic Origin?	(Specify Yes or N	o- 14. Red	ce - America	an Indien,	
21215-0020	or it	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes If Yes, Gr Year or D	^{2□N} 1943 -	1 ☐ Yes 2 ☑		ono moun, oto.,	Specif	y:		
ŏ	ture hox	P	15. Decedent's I		1945	Decedent's Usual Oc	cupation		16b. Kind of 8	Whi		
15	in 72	Completed	(Specify only highest g	rede completed)		(Give kind of work do life. DO NOT use re	ne during most of w	vorking	TOO. KING OF D	dan least in iç	lustry	
7	with than 6.	E	Elementary/Secondary (0-12)	College (Salesman			Food	1		
0	Hygie ther ent, p		17. Father's Name (First, Middle, Las	it)		Jaresman	18 Mother's N	ame (First, Middle	Food			
an	S should be filed within end Mental Hygiene. s marked other than aurmatic event, the Mental for	Be C	William Ehrheart	*					e, marcen sumen	110)		
Maryland	s 1 end 2 should I Health end Meni tem 27 Is marked other traumatic	2	19a. Informant's Name/Relationship		405	Marking Address (Or	Ada Lo		O	0	0.41	
Z	2 9 9					Meiling Address (Str						
	Health Health em 27		Leona Barbara Ehr	neart (12 Horizo Disposition (Name of						
Baltimore,	Pages nent of H nrt: If Ite		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removai from		y, cremetory or other	pleca)	Date	20c. Location -	City or To	wn, State	
E	ertmen ortant: Injury		4 Donation 5 Other (Spec			of Heaven	Cemetery	7/1/98	Silver	Sprin	ng, MD	
a	permit. Pages 1 end Depertment of Health Important: If Item 27 any Injury or other to once.		21. Signature of Funeral Service Lice	ensee	2.0	22. Name and Ad	Idress of Facility	DeVol Fu	neral Ho	ome		
10	Dep dus your		malall.	() A.	Hrons		Deer Park					
			23e. Part1. Enter the disease, or con	nplications that o	aused the death. Do n	Gaithers not enter the mode of	burg, MD dying, such as card	208 / / iac or respiratory	arrest.	- 1	Approximate	
	Physician		shock, or heart feilure. List ont	y one cause on e	ach line.			,			intervel Between Onaet and Death	
	/Medical		immediale Ceuse (Final		A VI 2 C 102			< - · · · · ·	_		1 014	
	Examiner		disease or condition resulting in death)	а.	Due to (or es e of M20) 10 U1	714 [N C KIL	CITO			1 17/1	
		9			Due to (or es e	consequence ot):	. 0	1010	C		1/	
	nsit	Examiner		Ь.			R 11	IJEN	>	i	Yomec	
_6	and and el-tra	xa	Sequentially list conditions, if eny, leading to immediate		Due to (or as a c	onsequence of):						
68760,	be		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						i		
28	phys s the	dic	resulting in death) Last		Due to (or es e c	onsequence of):				į		
OX	certificate be executed nding physician and use as the buriel-transit	n/Medical		d						į		
20	etten for us	lan								1		
o.	by the e	Physicia	Part ii. Other significant conditions	contributing to de	eath but not resulting In	the underlying cause	given in Part I.	23b. Did	l tobacco uee co	ntribute to	the cause of death	
J	2 2 2	by Phy	EMPHUSO	m 4				10	Ves 2□No	3 Prob	pably 4 Unknow	
0	ulres sign	D D	0					24a. Was	s an eutopsy	24b. We	ere autopay tindings	
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			,	- 14				10	Yes 2 No	1 🗆	Yes 2□No	
or vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical exeminer?	11				eath (Check only	one)			
5	Physic this al dir	ဥ	1 PYes 2 No		npatient 2 ER/Out	patient 3L DOA		Home 512 Res	idence 6 Oth	er (Specify	")	
_	ding P h. After t funera	ü	27. Manner of Deeth 1 □ Natural 5 □ Pending	28a. Dete	of injury 28b. T th, Dey Year) in	ime of 28c. in	njury at Work?	28d. Describe	how Injury occur	red		
0	Attanding or death. actor: After by the fune	at	2 Accident investigation			M 1	I ☐ Yes 2 ☐ No					
DIVISION	or Attan efter dest Director: d in by the	Ě	3 Suicide 6 Could not i	286. Place	of Injury - At home, faring, etc. (Specify)	m, street, factory, offi	ce		(Street end Numb	er or Aurei	Route Number,	
2	tal or A rs efter al Direction by led in by	Certification:		00/10/1	g. 2.0. (apoon))			2.1, 5. 75	, 5.5.9/			
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)	miner: On the be	best of my knowledge, esis of examinetion and ner stated.	death occurred at the Vor investigation, in m	e time, date and pla ny oplnion, death oc	ca, and due to the curred et the time	ceuse(s) end ma , dete end place,	anner as size	aled. the ceuse(s)	
	within 2 To the comple	₹ e	29b. Signature and title of certifier	0		29c. Lic	ense number		29d. Date signe	d (Month, L	Dey, Year)	
	- × - ō		R. 10. A	0 -	1.0							
1	2		Maple The	with	~ MU		11191		20	100	16,1998	
			30. Name and eddress of person who	completed caus	e of death (Item 23e) (Type, Print)				A 0	2000	

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State Registrar 31. Dete filed (Month, Day, Year)

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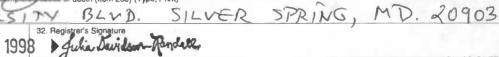
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					Ce	niiica	te or	Death		Reg. No.		1000
	Physician /Medical	Decedent's Neme (First, Midd		or I. E	scobar				2. Dete of De Month June 26	Day	Yeer	3. Time of Death 2:20 PM
	Examiner	4e Fecility Neme (If not institution 4312 Fernhill		nber)				4b. City, Town, or Silver Sp			of Deeth	.7
	Funeral Director	5. Sociel Security Number 579–70–5083		7. Age (In yrs. 6			or 1 Yea	r If Under 24 Hrs	8. Dete of Bir	th y, Year)	9. Birthpl Count	y lace (Stete or Foreign try) luras
Mand	B 18	Usuel Residence of Decedent 10e. Stete 10b. County	/	10c. Cit	ty, Town or Lo	ocation					10	Od. Inside City Limits
Man	\$ P	Maryland Monte	omerv	Si	lver S	prin	D.					1 ☐ Yes 2 No
Ę	or 28a-f e be notified Director	10e. Street and Number	, ,		2,402	_	ip Code			10g. Citizen of \	Whet Coun	try?
N. A.	200	4312 Fernhill	Road			21	0906			United	State	98
5-0020 72 hours after death with the Maryland	"naturel", or items 23a or 28a-f show social Expression must be notified at oleted by Funeral Director	11. Marital Status 1 Never Married 2 X Mar 3 Widowed 4 Divorced	Armed For 1 Yes If Yes, Giv	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaer or Datas:		U,S. 13. Was Decedent of If Yas, specify C		Hispanic Origin? (Sben, Mexican, Puer	Specify Yes or No to Rican, atc.)	No- 14. Race - Ar Black, W		an Indian,
2 P	ted	15. Decede	nt's Education		16a. Dece	dent's Us	uel Occi	upation	relina	16b. Kind of B	usiness/Ind	lustry
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should	7 is marked traumatic e	19e, Interment's Neme/Reletion		00040			ss (Stree	et end Number or R			State, Zip	Code)
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Te, M	Item 2 other	20a. Method of Disposition		20b. F	Diese of Diese	altina /Af				20c. Location		
Baltimore,	7 9 4	1 Donetion 5 Other (Specify) Silver Spring Communication										g, Marylan
Baltin permit. F	Important: any injury page.	21 Signature of Funere Service	- Lieen	M008	46 R	obert 557 W	A. I	Pumphrey Fu sin Avenue	, Bethesda	, Marylar	-Chevy d 208	Chase, Inc 314-3501 Approximete
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ox 68760, certificete be executed	rding physician end use as the burial-transit VMedical Examine	Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury			or es e conse							
68760,	physicians the burner of the b	thet initiated events resulting in deeth) Lest	C	Due to (or es e consequence of):							1	
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.O. By	ed for t	Pert II. Other significent conditi	ons contributing to de	ath but not res	sulting in the u	nderlying	causa	given in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death
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of Vita Physician:	s certificate director, par To Be Co	25. Wes case referred to medical exeminer?							eth (Check only	one)		
T de	0 0	1 X Yes 2 □ No	Hospitel: 1 🗆 i	npatient 2	ER/Outpatie	nt 3 🗆 [JUA		Home 5 Res	dence 6 Oth	ner (Specify	y)
E .	After the funeral funeral flori:	27. Manner of Deeth 1 Maturel 5 Pendi 2 Accident invest	ing (Mont	ot Injury h, Day Yeer)	28b. Time o Injury	M	28c. Inj W 1 [ury et ork? Yes 2 No	28d. Describe	how injury occur	rred	
- 2	al Director: After the din by the funeral Certification:	3 Suicide 6 Could deten	nined 288. Piece	of injury - At h ng, etc. <i>(Speci</i>		reet, fecto	ory, offic	â.		Street and Numi wn, Stete)	ber or Rure	I Route Number,
Hospita 24 bours	Funer etely fill dical		ng Physiclan: To the I Examiner: On the ba	isls of examine								
4 9	Me Me	20h Signature and Itie of cartific	i. (1 2	9c Lica	nsa number		29d. Data signe	ed (Month.	Day Year)

State Registrar

29b. Signature and little of gartif

30. Name and address of



use of deeth (Item 23e) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and menner as stated.

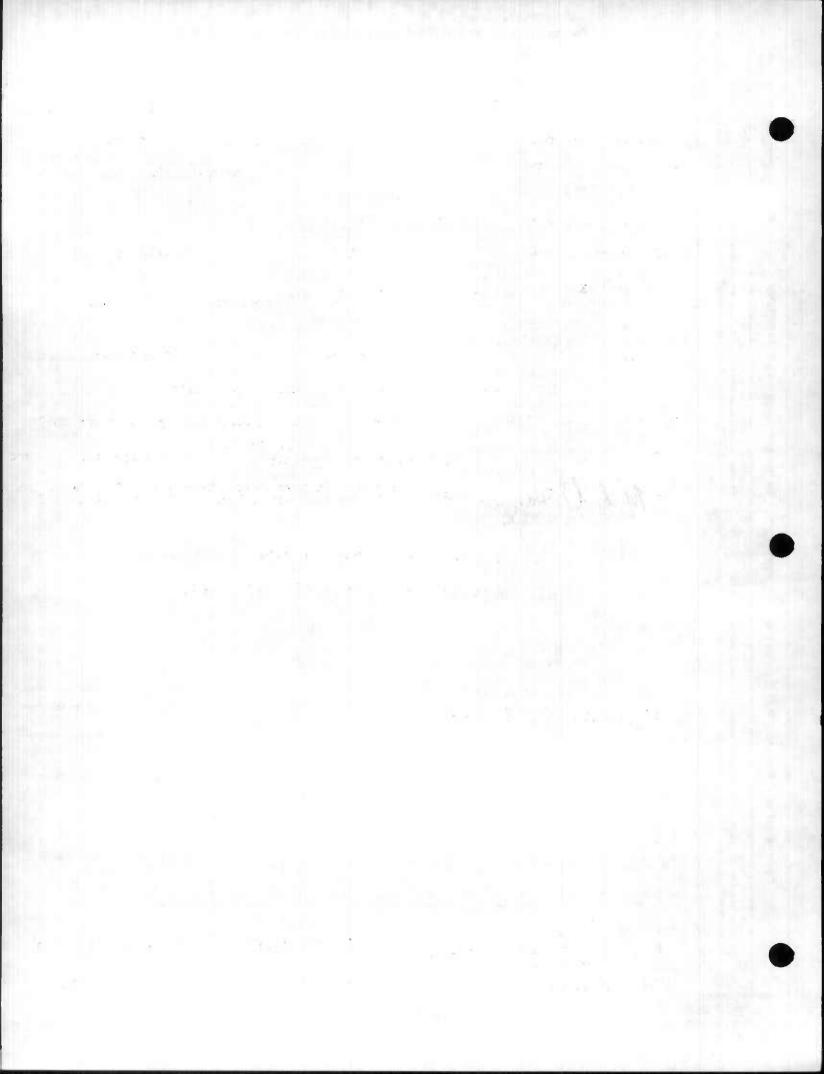
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end menner stated. 29c. Licansa number

0-19400

29d. Data signed (Month, Dey, Year)

JUNE 29 1998

DHMH 16 Rsv 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death AM Month Dev wing Donald 0100 June 26, 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ADVENTIST SHADY GROVE HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1⊠M 2□ F Sept. 14, 1909 382-05-6663 88 Michigan Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 MYes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 199 Rollins Avenue, #806 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1 ☐ Never Married 253 Married ☐ Yes 2 No Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Business/Industry 15. Decedent's Education (Specify only highest grade completed) Jackson County, MI Eiementary/Secondary (0-12) College (1-4or 5+) Road Commission Accountant 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Simeon E. Ewing Edna Spaulding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia K. Ewing/Wife 199 Rollins Avenue, #806, Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) July 1 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1998 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Fundire Service Ligensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01126 recomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final week disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 8 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to 24e. Was en eutopsy completion of cause of death? 1 Tyes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work?

Physician /Medical **Examiner** sician end buriel-transit that the death certificete be executed

Box 68760.

Records, P.O.

Division of Vital

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Hospital or Attandi 24 hours after death Funerel Director: A

24 hours

To the Hosp within 24 ho To the Fune completely fi

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Physician

/Medical

Examiner

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r than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or then any injury or other traumetic event, the Medical Examinat ODGs.

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Examiner Physician/Medical Completed Be

physician the buriel 98 been signed by the should be detached funeral director, Certification: To

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25. Was case referred to medical exeminer? 1 Yes 27. Menne of Death

5 Pending Investigation 1 Netural 2 Accident 6 Could not be determined 3 Suicide

4 - Homicida 29a. Certifier

28a. Date of Injury (Month, Dey Yeer)

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28e. Pieca of Injury - At home, tarm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28t. Location (Street and Number or Rural Route Number, City or Town, Stete) To Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner as stated.

29b. Signature and title of certifier

29c. License number

2 Medical Examinar: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted.

29d. Dete signed (Month, Day, Year) ne 26, 1998

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) GROVE Rd

SHADY 223 middhow Dismis 31. Date tiled (Month, Day, Year)

Rockville

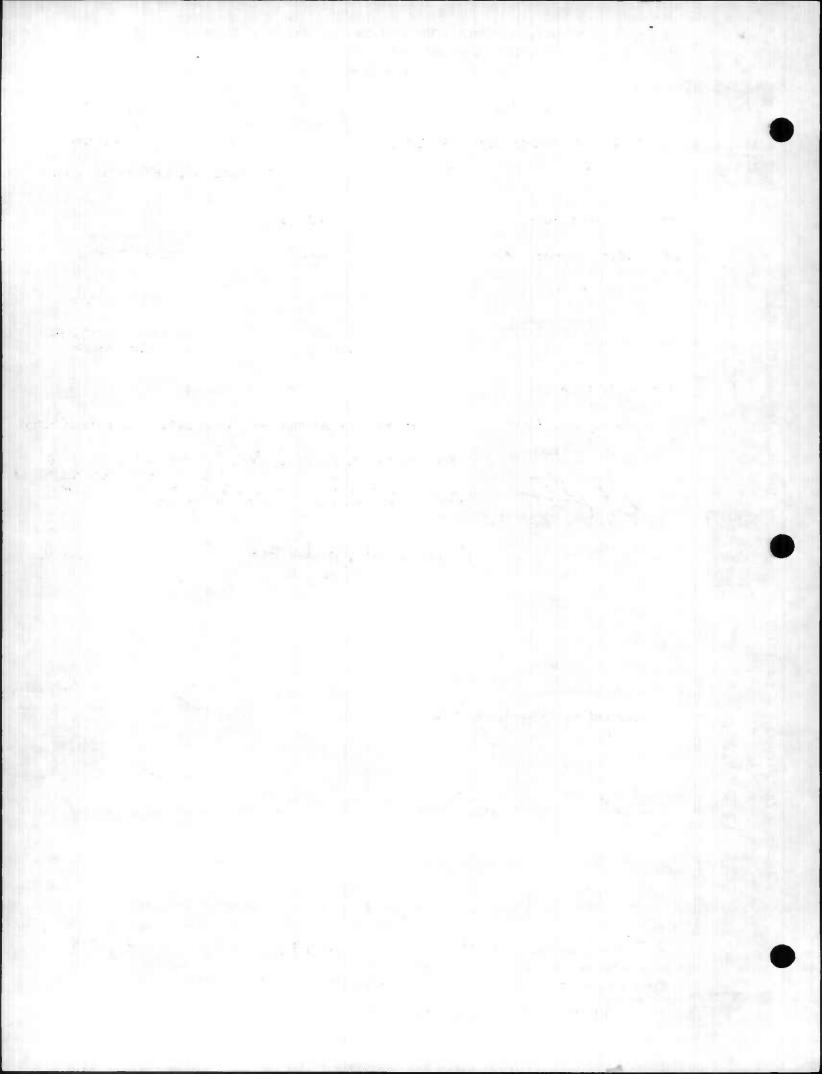
State Registrar

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DHMH 16 Rsv 6/95

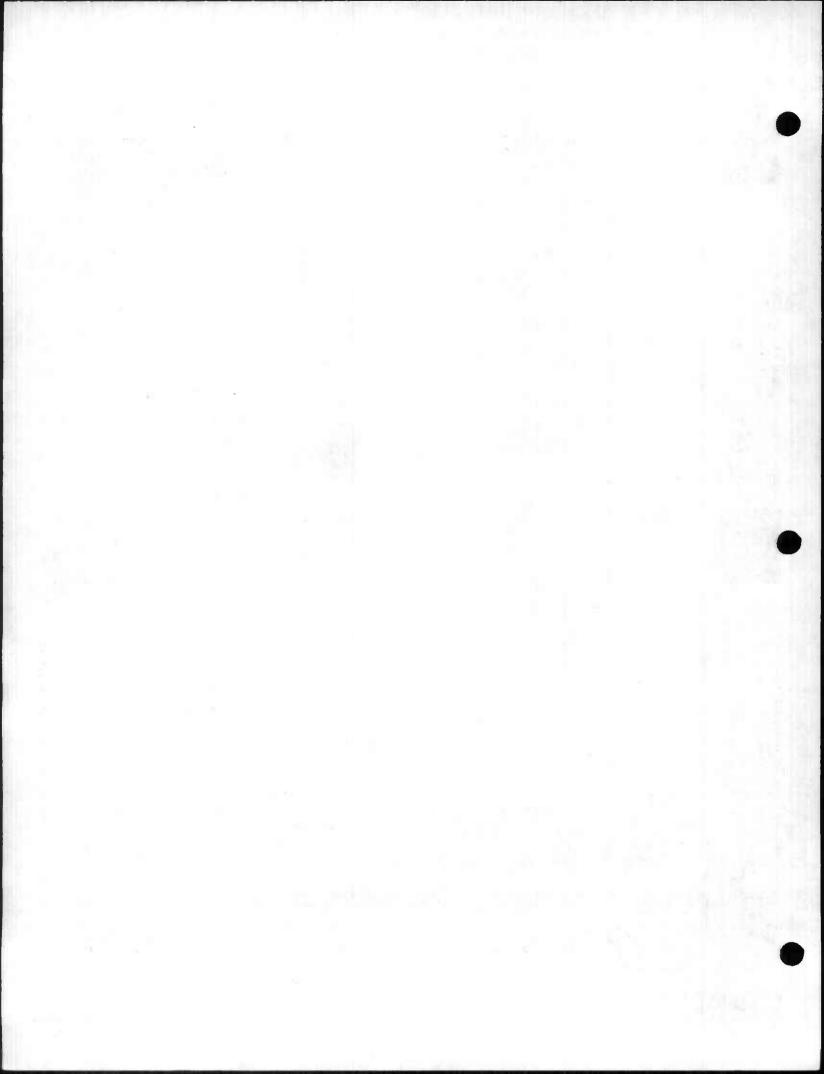


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month Vear 2:50PM 30 1998 AUDREY JUNE FI 7FY /Medical 4a. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth THE MEMORIAL HOSPITAL EASTON TALBOT 5. Scclai Security Number If Under 1 Year Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) NOV. 7, 1908 Birthplece (Stete or Foreign Country)
 M |) . **Funeral** 1 □ M 2 N F Months Days 212-10-4544A 89 Yrs. Director Usual Residence of Decedent death with the Maryland 10e. State 10b. County show 10c. City. Town or Location 10d. inside City Limits me 23e or 28e-f show Director 1 Ves 2 No MD. Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Homestead Manor 21529 USA Funeral Herns 2 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 11. Maritei Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. the Medical Examiner Peges 1 and 2 should be filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Be Completed by White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Business/Industry College (1-4or 5+) then Elementery/Secondery (0-12) Depenment of Heelth end Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, malk ELZEY Homemaker Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Dolby Aaron Susie Simmons Lo AUDREY 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Paul E. Elzev 331 Maple Avenue, Federal sburg, MD.21632 20e. Method of Disposition

↑ XBuriei 2 ☐ Cremation 3 ☐ Removal from State 20b. Placa of Disposition (Name of cometery, cremetory or other pleca) Date 20c. Location - City or Town, Stete Hillcrest Cemt. 3, 1998 Federalsburg, MD: 4 ☐ Donetion 5 ☐ Other (Specify) July 21. Signature(of Juneral Service Licensee 22. Neme end Address of Facility Williamson Funeral Home Federal sburg, MD. 21632 enter the mode of dying, such as cardiac or respiretory ar VXIOL 23e. Part î. Enter the diseese, or compilcations that caused the deeth. Do not enter the mode of dying, shock, or heert feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner eumonia Hospital or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest and the burief-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician hed for use es the burie Physician/Medical Due to (or es e consequença of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detech 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were eutopsy tindings available prior to completion of cause of death? 24e. Was en eutopsy performed? hes certificate 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Yes 22 No (inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Deeth 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturei 2 Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 Could not be 28e. Piaca of Injury - At home, tarm, street, factory, offica building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the ceuse(s) end manner as stated.

2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and menner stated. 29e. Certifier \$ 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month) Day, Year) 2 D - 5285530. Neme and address of person who completed cause of death (item 23a) (Type, Print) Rubio 219 South Washington St. Easton, ; MD. 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State '98 I Laydson. Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3 Time of Death

6:25 an

Carroll

10d. Inside City Limits

White

Finksburg, MD

Approximata Interval Between Onset end Death

1 ☐ Yes 2 No

Birthplaca (State or Foraign Country)

PA

1. Decedent's Name (First, Middla, Last) 2. Date of Deeth **Physician** Bernadette M. Ecker 25, 1998 June /Medicai 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Westminster Nursing & Convalescent Center Westminster 5. Social Security Number 7. Aga (In yrs. last birthdey) If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) **Funeral** Months 1□M 212 F Days Hours Director 85 214-28-0129 April 6, 1913 Usual Rasidance of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show ad other than "natural", or items 23s or 28s-f show event, its Medical Examiner must be notified at Director Carroll Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1408 Washington Rd. 21157 United States permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Men Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 Navar Married 2 Married 1 ☐ Yes 2 1 No Spacify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) 8 Owner & Operator Insurance Agency 17. Fethar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be 2 Curvin Small Blanche Topper 19a. Informant's Name/Raiationship (Typa, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) Philip L. Ecker, son 143 E. Main Street, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, cremetory or other place 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/29/98 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gardens 22. Name and Address of Facility
Pritts Funeral Home & Chapel 21. Signature of Funerel Sarvica Licensee 412 Washington Rd., Westminster, MD 21157 Katherine Protto - Sulitar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each life. **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Examine

-leunq physician Physician/Medical the attending p signed by the a Be Completed by page 2 has funeral director, Certification: To this After

To the Hospital or Attending Physician: The law requires that the death certificate be executed

efter death.

within 24 hours e To the Funeral D completely filled

the

filled in by

Medical

Division of Vital Records, P.O. Box 68760,

Sequentielly list conditions, if eny, laading to immediata ceuse. Enter Underlying Cause (Diseese or Injury that initiated evants resulting in death) Last

25. Was case raferred to medical examinar?

1 ☐ Yes

27. Menner of Death

1 Naturai

2 Accident

3 Suicida

29a. Certifian

4 Homicide

2 No

5 Pending

investigation

6 Could not be determined

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Osive

26. Plece of Death (Check only ona) Hospital:

28c. Injury at Work?

2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)

Due to (or as a consequance of):

Due to (or as a consequenca of)

23b. Did tobacco use contributs to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown

24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? 1 Yes 2 0 No 1 Yes 2 No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledga, daath occurred at the tima, data and pleca, and due to tha causa(s) and mannar as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred et tha time, date end place, and due to the causa(s) and manner stated. 29d. Data signed (Month, Day, Year)

29b. Signature and title of cartified 29c. Licansa number

hnk MD
32. Registrar's Signature Jona than

30. Neme and address of person who complated cause of death (Item 23e) (Type, Print)

31. Date filed (Month, Dey, Year)

chie Munic

1 Inpatient

28a. Data of Injury (Month, Day Year)

State Registrar

DN 8 5 1990 Fly Share Con.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death DENNIS FALK 06/16/1998 1:40 AM 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death FUTURE CARE CONTON HARBOR HEALTH BALTTMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Months 15M 20F Deys Hours 52 099.36.6049 JUNE 12, 1946 NEW YORK Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 SOUTH ELLWOOD 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 M Married 1 Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **ECONOMIST** HEALTH 17. Father's Neme (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Surname) MAX FALIK MIRIAM BRILL 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 10101 BENTCROSS DRIVE, POTOMAC, MARYLAND 20854 DR NANCY FALK/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 6/18/98 OLNEY, MARYLAND 21 Signature of Funeral Serviced Jourses 22. Name end Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately a shock, or heart failure. List only one cause on each line. AND 20852 Approximete Interval Between Onset and Deeth Immediate Cause (Final 1208 DAYS disease or condition resulting in death) Due to (or es e consequence of): Otys ASDILATION Numari a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) ORG AD BRAIN Due to (or as a consequence of): moran Veds US TRoma Part II. Other significant conditions contributing to death buf not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Ameuri A 1 Yee Szizur Donor 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death?

Physician /Medical Examiner

Physician

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Baltimore, Maryland 21215-0020

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Box 68760

Division of Vital Records, P.O.

physician end the burief-frensit attanding p signed by the a been page 2 certificate director this funerai After

Examiner Physician/Medicai

that the death certificate be executed þ Completed Hospital or Attending Physician: Be 2 Certification: eftar death. Director: Aft in by

24 hours Medical within 24 hor To the Fune completely fi \$ 0 (12

25. Was case referred to medical exeminer? 1 ☐ Inpatient 2 ☐ ER/Outpeflenf 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide

1 Yes 2000 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 281. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or Investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and menner stated. 29c. License number

29b. Signeture and title of partities

24276

MD

29d. Date signed (Month, Dey, Year) 6-1698

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) 35-

2801 mos-31. Date filed (Month, Day, Year)

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State Registrar

32 Registrar's Signature JUN 3 0 1998

CONTRACTOR STUDIES NAME OF A PARTY OF THE PARTY OF AND THE RESIDENCE OF THE PERSON OF THE PERSO

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Gilliam Month Dorah 0218 0 6 27-98 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Peninsula Center Theground Salisbury WICOMICO If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 215-58-5506 1□ M 200 46 Yrs Director VAI Usuel Residenca of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director PENNSAUKEN 1X Yes 2 □ No NJ Amder 10e. Street end Number 10g. Citizen of What Country? permit. Peges 1 end 2 should be filed within 72 hours after death with 1 Department of Health end Mental Hygiene. Important: If ham 27 is marked other than "natural" ... any linjury or other traumatic avant. MON AUE, USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No Rece - American Indian, Black, White, etc. 11. Merital Status 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16e. Decedant's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Sectory

18. Mother's Neme (First, Middle, Melden Surname) HOSPITAI 17. Fether's Neme (First, Middle, Last) Be LENARD 19b. Malling Address (Street end Number or Rufel Route Number, City or Town, Steta, Zip Code) HARMUN 19e. informent's Neme/Ralationship (Typa, Print) Rudo IPh Gillaam (Huskand) 6401 Walton Ave, Pennsaukent 308/09

20a. Method of Disposition

1 Removel from Stata

4 Donetion 5 Other (Specify)

Rudo IPh Gillaam (Huskand) 6401 Walton Ave, Pennsaukent 308/09

20b. Location - City of Town, State

7-2-98 Watts Ville Va. Friendship 7-2-98 Watts Ville, VA.

22. Name and Address of Facility whaten Funeral Home 21. Signeture of Funerel Service Licensee E. Whaten 22.171 Whaton Rd - According to 2.33 p. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate shock, or haart failure. List only one cause on each line. Onset end Deeth **Physician** /Medical Immediete Ceusa (Final diseese or condition resulting in deeth) Examiner accident The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immadiata cause. Enter Underlying Ceuse (Diseese or Injury that inflieted avants resulting in daath) Last Bud buriel-trar Due to (or as e consequence of): Box 68760, physician Physician/Medical Dua to (or es e consequance of): P.O. Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Myeloma Division of Vital Records, ò Completed 24b. Were autopsy findings eveileble prior to completion of cause of daeth? 24e. Wes en eutopsy performed? 2 4 100 After this certificate or Attanding Physician: 25. Wes case referred to medical exeminar?
1 ☐ Yes 2 ☐ No Be 26. Pieca of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 2 filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 5 Panding investigation CO38M Passenger can hit tree death. 6-27-48 1 Yes 2 No To the Hospital or Attandil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Sulcide 28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

3 - South - Blaces Rd. 4 - Homicide 1 Certifying Physictan: To the bast of my knowledge, death occurred et the time, deta end plece, and due to the ceusa(s) and mennar as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date end plece, end due to the causa(s) end menner steted. Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) 003599 6.27-98 D.M.E 30. Nama and eddrass of person who completed causa of daath (Item 23e) (Type, Print) TBulkeley, M.D., 108 Rine Bluff Rd, Salisbury, Md. 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State JUN 2 9 1998 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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	Physician /Medical	Don	ninic Ro	bert	Giunta	a					June			9:	20AM_
H	Examiner	4a Fecility Name	e (If not institution	n, give s	street and numb	er)				4b. City, Town, or	Location of De	ath 4c. Cor	unty of Dea	th	
L			ge Hill					7 811 4	4.14	Betheso			ntgom		
ľ	Funeral Director	5. Social Security 200-05-		6. Sex	M 2□ F	Age (In yrs	. last birthday Yrs.	Months Months				Birth Day, Year) 9. 191	9. Bir C	thplace (Si ountry) nnsv1:	ate or Foreigi Vania
	2	Usual Residence				140.00									
	show show	10a. State				10c. C	City, Town or Location								de City Limits Yes 2⊠No
	vith the Ma t or 28s-f s be notified	MD		tgor	nery		North Bethesda					10-00	-1145-10		163 2140
	with a						10f. Zip Code					10g. Citizen		ountry?	
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21215-0020	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at or other traumatic event, the Medical Examinar must be notified at	1 Never Ma	s arried 2[X]Mar d 4□Divorced	ried	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			If Yes, sp		of Hispenic Origin? (Scuban, Mexican, Puerl No Specify:	to Rican, etc.)		Black, Whi		
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215	bygiene. Ner then "neturing, tra Medical Completed	Elementary/Se	oecify only highe econdary (0-12)	sr grade	College (1-4	or 5+)	(Give kind of work done during most of working life. DO NOT use retired)				rking				
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	should be and Mental Is marked of umatic eve				Rosa LaMantia								tate. Zip Codel		
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	1 and Health em 27 ther tr	GIOTIA 20a. Method of D	F. Giun	ta	(W:	ife)	11408 Place of Disp	S Luxi	man	or Road, N	Jorth B	ethesda 20c. Locati	MD City of	2085	52 te
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	/Medical	Immediete Ceus disease or condi			Sep	sis								48 1	nours
	Examiner	resulting in death	h)	8.			or as a conse	quence of):						
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ó	tificate be executed by physician and as the buriel-transit	Sequentially list if eny, leading to cause. Enter Un	conditions, Immediate	ſ°			or as a conse							1	
68760,	ate be hysici the bu	Cause (Disease that initieted eve resulting in death	or injury	c		Due to (or es a conse	quence of)):						
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E E	cate hes page 2	Demen	ntia (mu	ılti	infarc	t)					10	Yes 2.5kN	lo	1 ☐ Yes	2□ No
of Vital	ysiclan: The sentificate director, pag				osnital:					26. Place of De	ath (Check onl	y one)			
ot	hys his al di		IXNo aath	n			ER/Outpatie		NA		fome 5 □ Re			ecify)	
vision	After fune	1 Natural 2 Accident	5 Pendii investi	igation	28e. Date of (Month,	Day Year)	Injury	M		njuryat Work? I ☐ Yes 2 ☐ No	Zou. Describ	e how injury or	JUII OU		
N N	or death rector: by the	3 ☐ Suicide 4 ☐ HomicId	6 Could detern	not be		Injury - At h	nome, farm, s	treet, facto	ry, offi	ce	28f. Location City or 1	(Street and Nown, State)	lumber or F	lural Route	Number,

State

Medical Cer

29a. Certifier (Check of one)

29b. Signati

50 W Edmonston Drive, Rockville, MD Paul T. Noone, M.D., 20852

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannerstated.

29c. License number

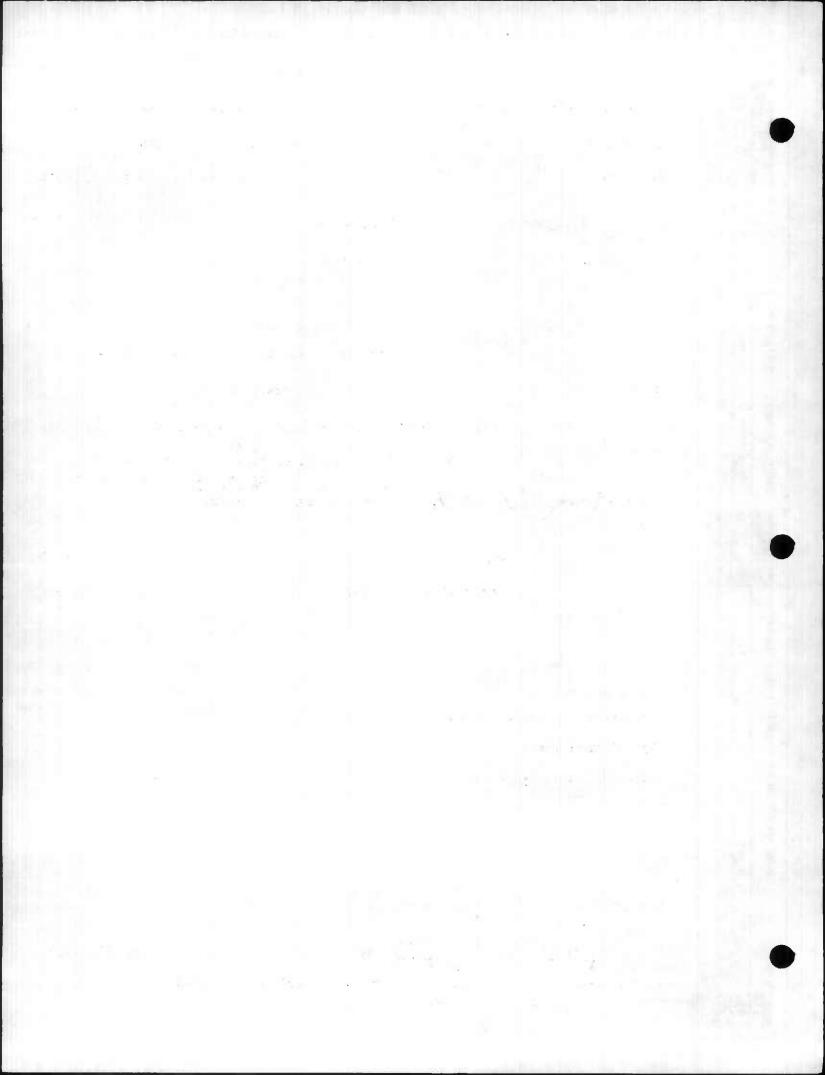
D07471

29d. Date signed (Month, Day, Year)

June 30, 1998

30. Name and eddress of person who completed cause of dealth (Item 23a) (Type, Print)

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedant's Nama (First Middle Last) 2. Deta of Death 3. Tima of Death 24, 1998 S. JUNE ALNORA 12:43 PM GRANGER 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE
Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of MONTGOMERY 8. Date of Birth (Month, Dev. Year) Oct. 22,1926 9. Birthplaca (State or Foreign Country)
N. Carolin 1 □ M 2 □ F Months Days Hours Min. 71 Carolina 10c. City, Town or Location 10b County 10d. Inside City Limits 1 No Yes 2 No Monggomery Potomac 10f. Zip Code 10g. Citizen of What Country? 11703 Charen Lane 20854 U.S.A. 14. Rece - American Indien, Bleck, White, etc. 12. Was Decedanf Ever in U,S. Armed Forcas? Wes Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yas 2X No If Yas, Giva Year or Datas: 1 Navar Marriad 2 Married Specify: Black 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 5 yrs Biologist N.I.H. 18. Mothar's Nama (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middle, Last) Arthur Stewart Mary E. Blackmore 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) William P. Granger (Husband) 11703 Charen Lane, Potomac, MD 20854 20b. Place of Disposition (Neme of cametery, crematory or other place) 20c. Location - City or Town, Stata Burial 2 Cremetion 3 Ramovai from State 6/29/98 Parklawn Mem. Park Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Fecility
SNOWDEN FUNERAL HOME, P.A.
BOCKVILLE, MD 20850 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or hear in lure. List only age cause on each line. Approximata Intarval Between Onset and Deeth acute Respiratory tailure 4 hRS Myocardia Idiopathic Pulmonary tibrosis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death?

Physician /Medical Examiner

The law requires that the death certificete be executed

Hospital or Attending Physician:

signed by the e

been si

s certificate has b director, page 2 s

this funeral

After

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24 hours eff Funeral Di letely filled in

To the Hosp within 24 hos To the Fune completely fi

10

director

by

Completed

Be

To

Certification:

Medical

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

237-38-9001

Usual Rasidance of Dacedani

10e. Street and Number

20a. Mathod of Disposition

Immediata Causa (Final disaasa or condition rasulting in daath)

11. Marltal Status

10a Stata

Director

Funeral

by

Completed

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Director

the Maryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23s or 28s-f show shy Injury or other traumatic event, the Medical Examiner must be northed at once.

Examiner physicien end s the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disease or injury that initiated evants resulting in death) Last Physician/Medical ettending p 80

> 1 Yas 2 No 26. Placa of Death (Check only ona)

1 □ Yas 2 □ No

25. Was case referred to medical axapriner? 1 Yas 2 No 27. Mannar of Death

28a. Data of Injury (Month, Day Year) 5 Panding invastigation

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of

28a. Placa of Injury - At home, farm, streat, fectory, office building, atc. (Specify)

Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred 281. Location (Street end Number or Rurel Route Number, City or Town, Stata)

29a, Cartifiar (Check only one)

1 Natural
2 Accident

3 Suicida

4 Homicide

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

29b. Signalura end litia of cartifian

6 Could not be delamined

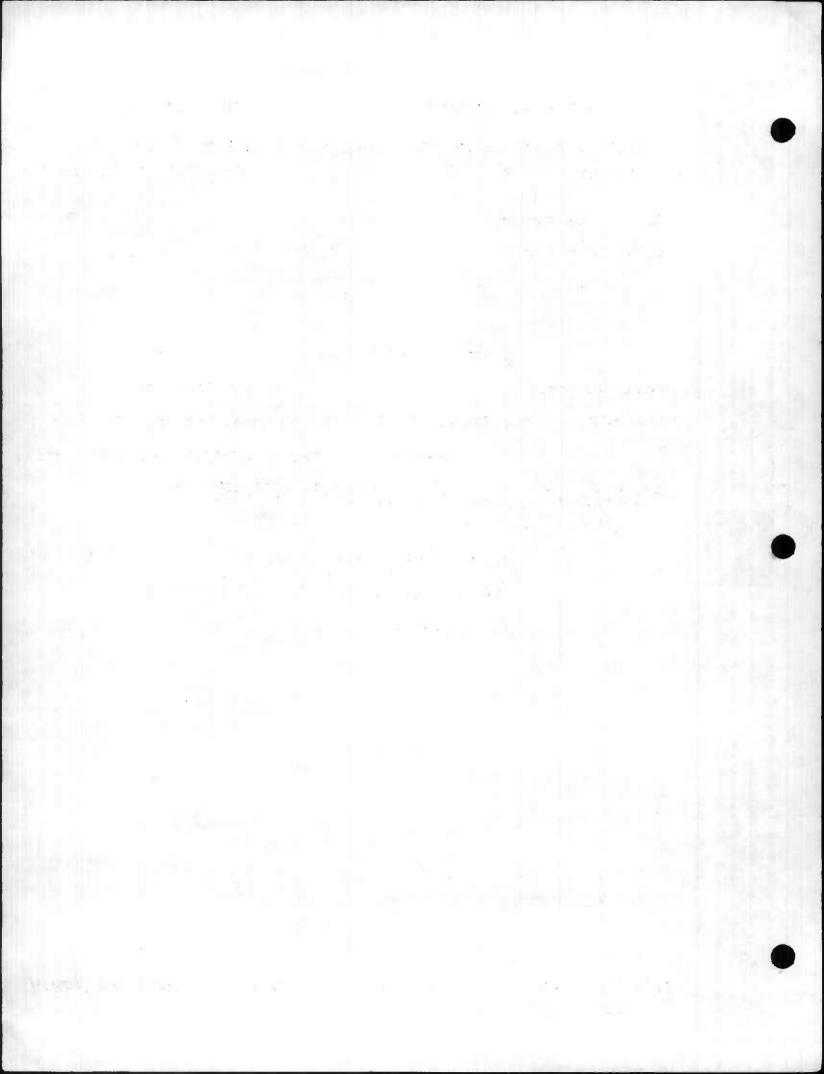
29d. Date signed (Month, Day, Year) 6-25-98

30. Nama and addrass of person who completed causa ot death (Itam 23a) (Type, Print)

Bak 9406 32. Degistrar's Signatura

Georgetown Rd Bethesda, Md 20814 010

State Registrar



State of Maryland / Department of Health and Mental Hygiene 98 21603

						Ce	rtificate	of L	Death			Reg. N	lo.		- 1	, 00
	Di		1. Decedant'e Nama (First, Mid	dla, Last)							2. Dete of De	eeth		Voor	3. Tim	e of Death
	Physic /Medi			Mary Ce	celia	Guthri	e				Month	20	ay	98	3	4.m
	Exami		4a. Facility Nama (If not Institut	ion, giva street and n	umber)			4	b. City, To	wn, or Lo	ocation of Dee	th 4	c. County	of Death		
			Hill Heaver	N.H.					Ad	elph	i	I	Princ	e Geo	orge	s
	Funeral		5. Social Security Number	6. Sex	7. Age (In)	yrs. last birthday	If Undar 1 Y		If Under		8. Dete of Bi (Month, D					
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	inylar inhow	_	10a. Slata 10b. Coun	ty	10c.	City, Town or L	ocation							11		e City Limits
	P. P.	cto	Md. P.	G.		Col	llege 1	Par	ck						1 🖾 Y	res 2□No
	or 2	Oire	10e. Streel and Number				10f. Zip Co	de				10g. C	Itizan of	What Coun	try?	
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	ygies	Col	12			Data	a Entr	У						Corp	orat	ion
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	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I health and Mental Hygiene. I have 25 or 2844 show other traumatic event, the Mexical Examiner must be notified at		Benjamin S. Gu	thrie (So		501		St	. C	olle	ge Par	-	Md.	207		
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Ö	al or Attendir s after death. M Director: Af ed in by the fu	e l	4 Homicide	buil	ding, etc. (Sp	ecify)					City or To	wn, Sta	(a)			
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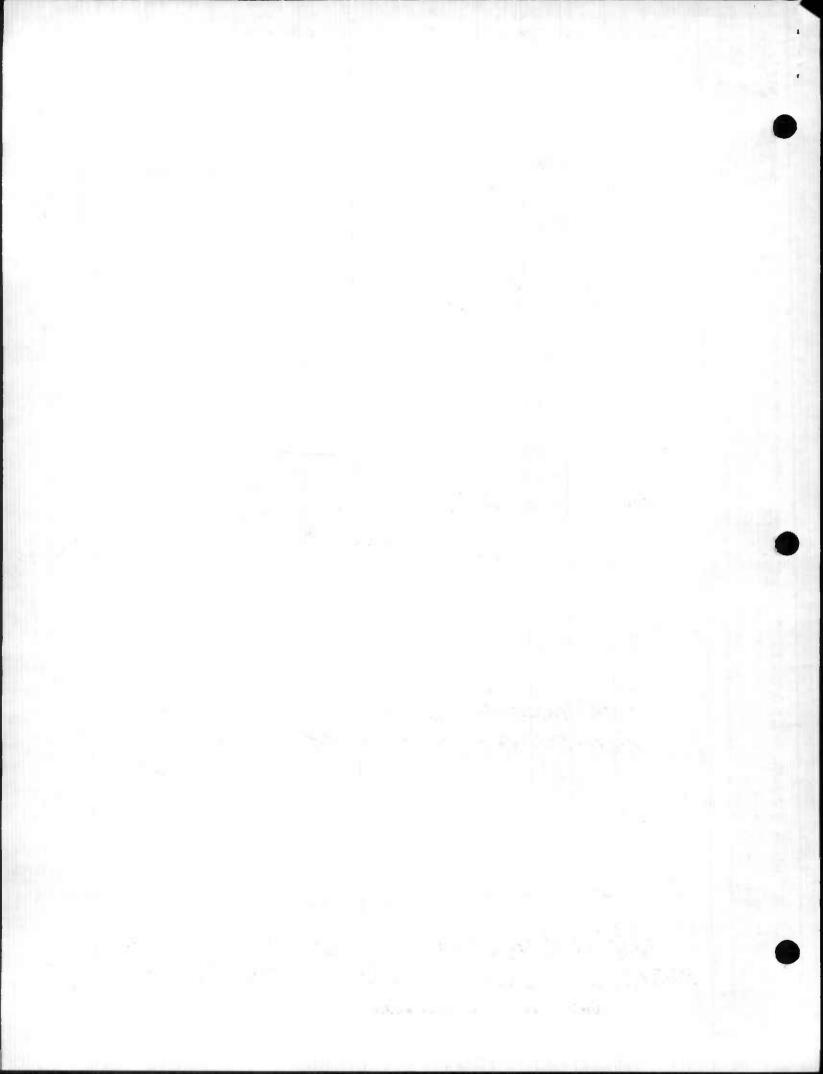
and hearth Many to the second second second 나를 보냈다. 그리는 것은 What well plant agreement in the control of the background at the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 20b, per F.H. 6/30/98, Carroll County, cew Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day 1998 **Physician** Month James Joseph Guerrini June 28, 2:15 an /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1307 Somerset Court New Windsor Carroll 5. Social Sacurity Number if Undar 1 Yaar If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funerai** Days Hours 1 M 2 □ F Yrs Director 185-16-8874 74 April 5, 1924 PA Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Insida City Limits rel', or items 23a or 28a-f show Examiner rount be notified at MD Carroll New Windsor 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1307 Somerset Court 21776 United States Funeral death 12. Was Decedant Ever in U,S.
Armed Forcas?

1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Detes: WWIT Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 naturel', or 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) the Medical 15 Decedent's Education 16b. Kind of Businass/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Engineering 7 is marked other treumatic event, it Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) . Pages 1 and 2 should be fill ment of Health end Mental Heart: If Item 27 is marked oth jury or other treumatic even Be Nick Guerrini Antoinette Delett 19a. Informant's Name/Reletionship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Florence Marie Guerrini, wife 1307 Somerset Court, New Windsor, MD 21776 ition (Name of Date 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or 07/01/98 7/2/98 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Cemetery
22. Name and Address of Fecility Owings Mills, Md 21. Signature of Funeral Service Licensee Pritts Funeral Home & Chapel 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heer fellure. List only one cause on each line. 412 Washington Rd., Westminster, MD 21157 Approximate Intervel Between Onsat and Deeth **Physician** UNEVMONIK /Medicai Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): P.O. Box 68760. the Due to (or as a consequence of): for use es Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? PARKINSONS 1 Yes 2 No 3 Probably 4 Unknown Records, þ DEMENTIA - ALZHONMINE 24b. Were autopsy findings available prior to complation of causa of death? Completed 24a. Wes en autopsy performed? page 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No Be 25. Wes case referred to predicel examiner? 26. Place of Death (Check only one)

of Vital Division

certificate Physician: director, Other: 4 Nursing Homa 5 Presidence 6 Other (Specify) Certification: To 1 Yas 200 No 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending Investigation within 24 hours efter death. To the Funeral Director: A 2 Accident 3 ☐ Suicide 6 Could not be determined in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical completely (Check only one) the 29b. Signature a 29c. License number 29d. Dete signed (Month, Day, Year) Utem 23a) (Type, Puni) O. Bex VGI West nuarte 31. Date filed (Month, Day, Year) 32. Registrar's Signeture 0 1998 un dikusteer kaalell Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death Month Dev 22:30 W. Hawkins arry 26 June 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Rathmore
Tunder 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year)
May 16, 1949 Baltimore Mary land of Medical University Center 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 6 Sex Birthplece (State or Foreign Country) Deys 10 M 2□ F Months 212-54-2793 49 Washington, DC Usuei Residence of Decedent 10d. Inside City Limits 10a Stete 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20895 10804 Stella Court USA 12. Wes Decedent Ever In U.S. Armed Forces? 1 53 Yes 2 ☐ No If Yes, Give Yeer or Deles: Vietnam Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 Never Married 2 Nerried 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Police Officer Federal Government 17. Fether's Neme (First, Middle, I ast) 18. Mother's Neme (First, Middle, Meiden Sumame) Walter Henderson Hawkins Mariana Jenkins 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Margot Hawkins (wife) 10804 Stella Court, Kensington, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) MD Veteran's Cemetery 7/2/98 Cheltenham, MD 22. Name end Address of Fecility 21. Signefure of Funeral Service Licensee Francis J. Collins Funeral 500 University Blvd. West Home, Inc. Silver Spring, MD 20901

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or Neert feilure. List only one cause on each me Approximate Intervel Between Onset end Death immediate Cause (Final disease or condition resulting in deeth) abdominal Due to (or es a consequence of): metastatic Years Concer Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No bowel Caranonna 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? status post lypis of archesions and small bowel completion of ceuse of deeth? resection 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28c. injury et Work? 27. Menner of Deetl 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Weturel 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner

Examiner

Physician

/Medical

Examiner

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permit. Pages Department of important: If its any injury or o

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

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physician and the burial-trensit that the death certificate be executed for use as 1 signed by the lew requires certificate hes t firector, page 2 s this funerai After

Division of Vital Records, P.O. Box 68760, Hospital or Attanding Physician: s after deau... 24 hours a

Physician/Medical þ Completed Be 2 Certification:

To the Hosp within 24 hor To the Fune completely fi 2021

State Registrar

Medical

6 Could not be determined

3 Suicide

29a. Certifier

4 | Homicide

29b. Signeture end title of certifier

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

0360

29c. License number

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Dept. of Surgery University of Marked Medical Ler

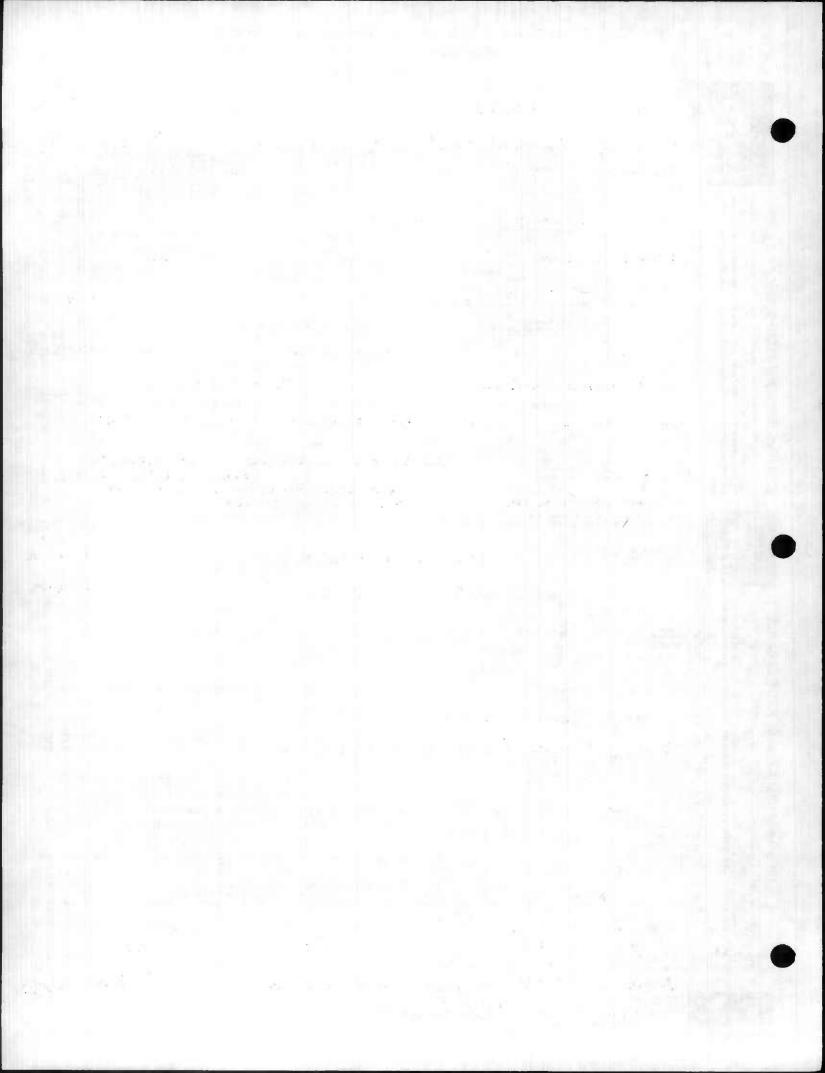
30. Name end eddress of person wh completed cause of deeth (Item 23a) (Type, Print)

SZOSTAK MO 31. Dete filed (Month, Dey, Year)

JUN 3 0 1998

32. Registrer's Signeture Julia Savidson

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Amend #11,7/6/98, BMW, Montg. Co. Certificate of Death Amend #5,7/2/98,BMW,Montg.Co. 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Tima of Death Month Yaar **Physician** June 25, 1998 5:25 a.m. Mr. John Mullen Hannan /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery General Hospital Montgomery Olney If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) Feb. 21, 1916 9. Birthplece (State or Foreign Country) Louiville, KY 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 12 M 2 F Yes 82 Director Usual Residence of Decedent death with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at Silver Spring MD Montgomery 1 X Yas 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 3701 International Drive 20906 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? filed within 72 hours after 1 Never Married ** EMarried 1 X Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 WWII 1 Yas 25 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Institutes of Elementary/Secondery (0-12) College (1-4or 5+) Hygiana. Health Executive Officer 18. Mother's Name (First, Middle, Meiden Sumeme) 17 Fether's Name (First Middle Last) s 1 end 2 should be fill I Health and Mantal H tem 27 is marked oth Katherine O'Bryan William Owen Roberts Hannan 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. informant's Name/Relationship (Type, Print) 17228 Evangeline Lane, Olney, Md. 20832 Paul Hannan Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata Date 20a. Method of Disposition Pages nent of P 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate Of Heaven Cemetery 6/29/98 Silver Spring, MD 22. Name and Address of Facility
Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue of Funeral Service Licenses N.W., Washington, D.C. 20016 the slimite, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory errest, in liture. List only one cause on each line. Approximete Interval Between Onsat and Death Physician Vascular Arcident Cerebro /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examine per felision thet the death certificete be executed physician and the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): for use as 23b. Did tobacco use contribute to the cause of death? signed by the a d be detached f Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ been signature 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? cartificeta has b lirector, page 2 s The 1 Yes 2 No 1 Yes 2 No Physician: Be 25. Was cese referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 20 this funeral 28e. Data of Injury (Month, Day Year) 27 Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: After or Attending 5 Pending 1 Neturet 1 Yes 2 No r death. investigation Director: / 2 Accidant 6 Could not be determined 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide To the Hospital or A within 24 hours after To the Funeral Direc completaly filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Data signed (Month, Dey, Year) 10 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) 1811 Pr. Philip Dr, Suite 212 Olney mp 20832 Mendhirala 31. Date filed (Month, Day, Year) 32. Begistrar's Signeture State JUN 2 9 1998 Alia Davidson-Randell Registrar

DHMH 16 Rev 6/95

HE REPORT THE PROPERTY AND ADDRESS OF THE PARTY he April 24 May 11 and 12 Francisco de l'Ares The Part of the Control of the Contr non " perioden natar nu i Ara The second was properly to the second The Administration of the Property of the Parish the authorized that well artists from a contithe E . Total has had there were

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Examiner must be notified at		Usual Residence of Decedent 10a. State 10b. Count MD Ke	•			City, Town or L						10d. Inside City Limits	
Direct	-	10e. Street end Number 21106 Rock Hal	7 A				10f. Zip Code			10g. Citiz	en of Whet C		
by Funeral Director		11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	rrled	12. Was Dec Armed Fo 1 Yes If Yes, Gi Yeer or D	orces? 2X No ve	n U,S. 13.	Wes Decedent of if Yes, specify Cut	Hispenic Origin? (Speen, Mexican, Puerto	pecify Yes or No Ricen, etc.)	No- 1	S.A. 4. Race - Am Biack, Wh		
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To Be Complet		17. Father's Neme (First, Middle Unknown	, Last)					18. Mother's Nam Unkr		le, Malden S	Su <i>m</i> ame)		
		19a. Informent's Neme/Relation James A. Perkin			-law			Rock Hal			Town, State,	Zip Code)	
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Fune Direct	_	5. Social Sacurity Number 6. S 213-22-8532 Usual Rasidence of Dacadant	6ax 1XIM 2□F 7	7 Yr	Months Dev	ar If Undar 24 I	Hrs. 8. Date of Birth Nin. (Month, Day		place (Steta or Foraign
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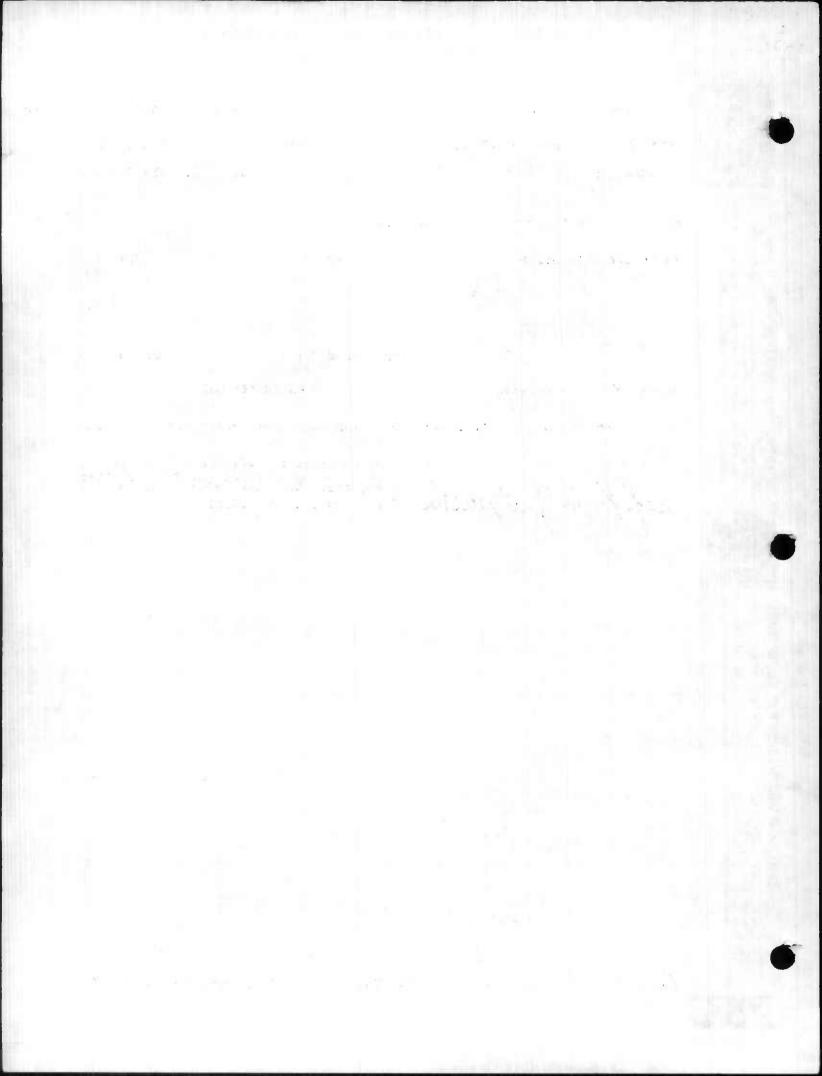
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District de la company de la c	ide	building, e	tc. (Specify)					City of Town,	31616)		
Throad A San Certifier (Check on Check	1 Certifying Phy	sician: To the best	of my knowledg	ge, deeth o	ccurred et the t	ime, dete en	d plece, end	due to the ce	use(s) end me	enner es stet	ed.
DIVISION To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune (Check on one) Medical Certification And Call Certification 3 Certification 3 Sincipi	2 Medical Exam	iner: On the basis of and manner of	examinetion e	nd/or Inves	tigation, in my	opinion, dea	tn occurred	at the time, de	te end plece,	and dua to th	ne cause(s)
# 29b. Signature	and title of certifier	11			29c. Licen	sa number		29	d. Data signe	d (Month, De	y, Year)
15	/	/ 41	5			CME			JUNE 2	4, 199	8
	eddress of person who o	completed cause of	deeth (Item 23e) (Type, Pri							
Dav	71	Fowber			enn St	reet,	Baltir	nore, M	arylan	d 2120)1
State 31. Dete filed	Month, Day, Year)		rer's Signature	Randa							

JUN 2 9 1998



		ite	m#8 per FH G761 7/31/		Marylai		artment ertificate			Mental Hy	/giene	98	21610
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	hysici /Medic		Alice El:	zabeth Kl	lein					July 2	. 1998	8 Year	1342
	xamin		4a. Facility Name (If not institution, g	nive street and numb	oer)				4b. City, Town, o	or Location of Dee	-	ounty of Deat	
14.7			Kent & Queen Anne	e's Hospit	tal				Chester	town	Ke	ent	
	neral ector		218-24-2555	. Sex 1 □ M 2 1 F 7.	Age (In yrs.	lest birthday Yrs.	Months	Deys	If Under 24 H Hours Mi		rth ey, Year) 19 2. 1998	930 9. Birti Co Mar	hplace (Stete or Foreign untry) yland
pur	*		Usuel Residence of Decedent 10e, Stete 10b, County		10c C	ty, Town or L	ocation						104 1-14-02 1/22
Maryla	od a la	ō	Maryland Kent										10d. Inside City Limits 1 Yes 2 □ No
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with	3a or		123 Philosphers	Terrace				216	520		U.S.		only:
deatt	Ner ma	Funerai	11. Marital Status	12. Was Decede	ent Ever in L	J,S. 13.	Wes Decede			(Specify Yes or Ne erto Rican, etc.)		Race - Amer	
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<u> </u>	the Med	Completed	(Specify only highest g Elementary/Secondery (0-12)	College (1-4	or 5+)	life.	DO NOT use	retire	dunng most of w d)	rorking			
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Exam	niner		resulting in death)	. Card	Due to (or es e conse	quence of)://	7	COP				, cumics
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of Vita Physician: this certific	0	ToB	examiner?	Hospitel: 1 Inpe	atient 2	ER/Outpatie	nt 3 DOA	Oth	or	Home 5 ☐ Resi		Other (Spec	eifv)
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Vision Attending	the fu	atic	2 Accident Investigeti	on	, , , , ,	mjory	M		Yes 2 □ No				
- X# =	ed in by	Certification:	3 Suicide 6 Could not determine	28e. Place of	Injury - At he etc. (Specif	ome, farm, st	reet, fectory,	office		28f. Location (City or To	Street and N wn, State)	lum <i>ber or Ru</i>	ral Route Number,
To the Hospital or within 24 hours a To the Funeral D	completely filled in by	edical	29a. Certifier (Check only one)	hysician: To the bes miner: On the basis and menner	of exemine	wledge, deet tion end/or in	h occurred et vestigetion, Ir	the tim	ne, dete end plea pinion, deeth occ	ce, end due to the curred et the time,	ceuse(s) en dete end pla	d menner es ace, end due	steted. to the ceuse(s)
To the	COM	-	29b. Signeture end title of certifler				29c. I	Licens	e number	T	29d. Dete s	Igned (Month	, Dey, Year)
10			> 164 Clean	n, m	P.		1	1) 2	13/3		7/	2/98	
			30. Name end eddress of person who	completed ceuse o	f deeth (Item	23e) (Type,	Print)	hes	lever	n, m	D 2	1620	2
Re	Stat egistra	~	31. Dete filed (Month, Dey, Year)	JZ. Megis	Strat 2 SIMINA	iture						-	

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nema (First, Middia, Last) 2. Data of Daath 3. Tima of Death ELLA A. KARABELL JUNE 28 1998 7:00am 4a. Facility Nema (if not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthpleca (Stata or Foreign 8/2/02 LANCASTER, PA 188-09-9905 95 Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Insida City Limits MONTGOMERY ROCKVILLE MARYLAND Yas 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? UNITES STATES 6121 MONTROSE RD 20852 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes X No Specify: 3 □Widowed 4 □ Divorced 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working Me. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 OWNER GROCERY/FOOD STORES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MORRIS R. PROLER JENNIE LEAPMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11430 STRAND RD #112 ROCKVILLE, MD 20852 MAURICE DUNIE SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20s. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KING DAVID MEMORIAL GARDN6-29-98 FALLS CHURCH, VA 21. Signature of Feneral Service Licer DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILL PIKE, ROCKVILL, MD 20852 ns that obseed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ease, or complications. List only one Immediate Cause (Final disease or condition resulting in death) ementer Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performad?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

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Director

Funeral

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r than "naturel", or items 23e or 28a-f shor the Medical Examiner must be notified at

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Baltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

Be Certification: To

Examiner Physician/Medical þ Completed

돭 physician a the burla 2 attending ed by the detached signed by t peeu has page 2 cartificata Hospital or Attending Physician: After death. after deati Director: thin 24 hours after de the Funeral Directo impletely filled in by th To the within 2.
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State Registrar

1 Yas 2 No 25. Was case ratarred to medical 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at (Work? 28d. Dascribe how injury occurred Neturel 5 Pending Invastigation 1 Yas 2 No 2 Accidant 6 Could not be detarmined 3 Suicida 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicide to the best of my knowledge, death occurred at the time, data and plece, and due to the cause(s) and mannar as stated.

| Medical Examinar: On the best of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifian (Check only one) 29b. Signature end title of certifier 29c. License number

D 23958

29d. Date signed (Month, Day, Year)

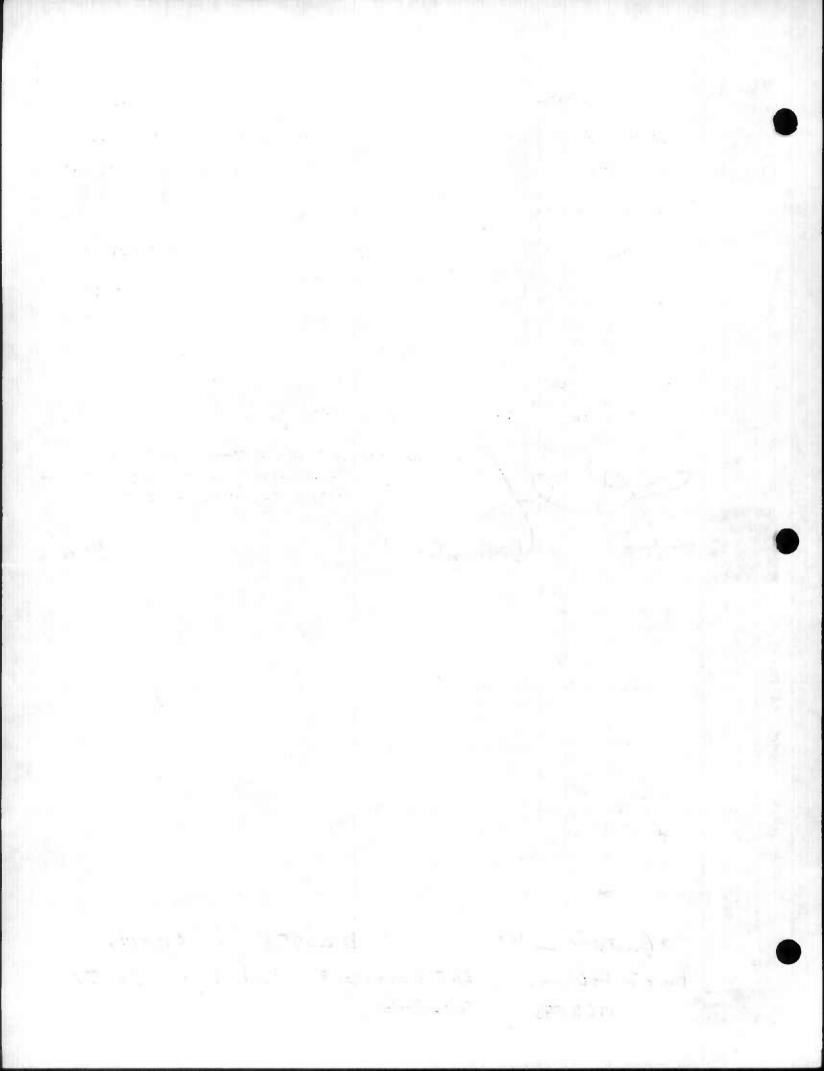
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30. Nema and eddress of person who completed cause of death (Item 23a) (Type, Print)

6105 Montrose Pd., Rockville, MD 20852 MD 31. Deta tiled (Month, Day, Year)

JUN 2 9 1998

32. Registrar's Signature Sha Devidor



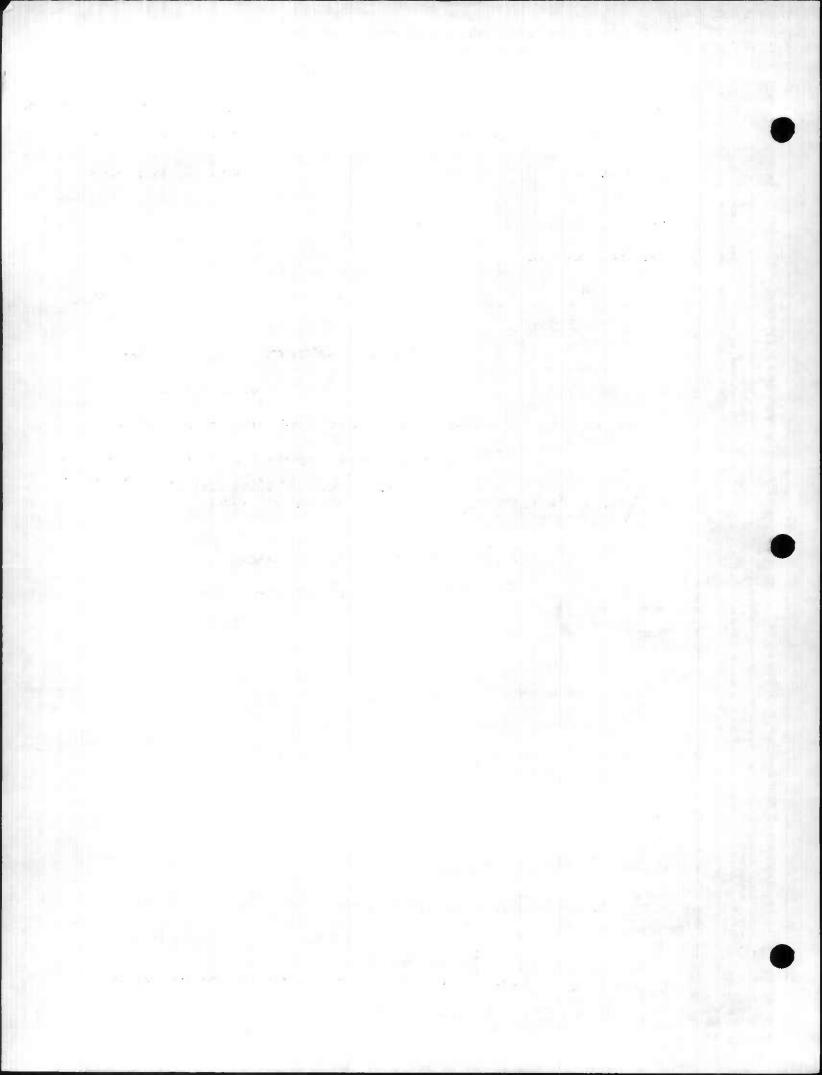
State of Maryland / Department of Health and Mental Hygiene

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Medical		Donna S	S. Kefa	uver				3-14-1		29, 199	
aminer	48			give street and no PITAL EM		ROOM		4b. City, Town, or Lo SILVER SE		4c. County MONT	of Death GOMERY
eral ctor		Social Security Nu 216-74-	-6662	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 42	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey Nov. 20	Year) 0, 1955	9. Birthplece (State or Fo Country) Maryland
rector	-	suel Residence of Da. State	10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City L
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P		Assed S							rine Wil		
	1	9a. Informent's Na			/1			and Number or Run			
	20	William a. Method of Disp		ver	20h P	Place of Dispos	sition (Name of	Road, Wh			02 City or Town, State
	-	1 Burial 2	Cremation	3 Removal from	State	cemetery, crem	atory or other pla				
any Injury or other to	-	4 Donation			Ga			emetery 7			Spring, MD
		A Signature of Pur	Heral Service (.icensee		Ho	me, Inc.	500 Uni	versity	Blvd.	ns Funeral West
		How	aen	- May	and .	Si	lver Spr	ing, MD	20901		Approximate
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Registrar





State of Maryland / Department of Health and Mental Hygiene

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Physicia	_	Woodrow Wilson								Mont	h	1998	Yeer	
/Medica	_	4e. Fecility Neme (If not institution						Ah	City Town	June or Location of	24,		ty of Deeth	0728
Examine	er	Union Hospital			untv				Elktor				cil	
Funeral Director		5. Sociel Security Number 213-01-8999	6. Sex	7. Age	e (In yrs. les	st birthdey) Yrs.	If Under Months	r 1 Year	If Under 24 H		of Birth h, Dey, Y		9. Birth	plece (State or Fo ntry) Land
,		Usuel Residence of Decedent												
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ked c	To Be	William Loller							_	Baile				
and Mental Hygiene. Is marked other than aumatic event, the N		19e. Informent's Name/Reletion		t)		19b. Meiling Address (Street and Number or Rural Route N						City or Town	n, State. Zir	p Code)
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0		20e. Method of Disposition 1 X Buriel 2 Cremetion 4 Donetion 5 Other (5		from State	100	ce of Dispos netery, crem	sition (Ner natory or o	me of other plece)		Dete	20	c. Location	- City or To	own, Stete
Department Important: If any injury o once.	-	21. Signeture of Funeral Service	- 13	1	Zarei	10 Cell	Name en	nd Address	of Fecility Tenbei	, 1998	wnam	Fune	ral H	ome, P.A
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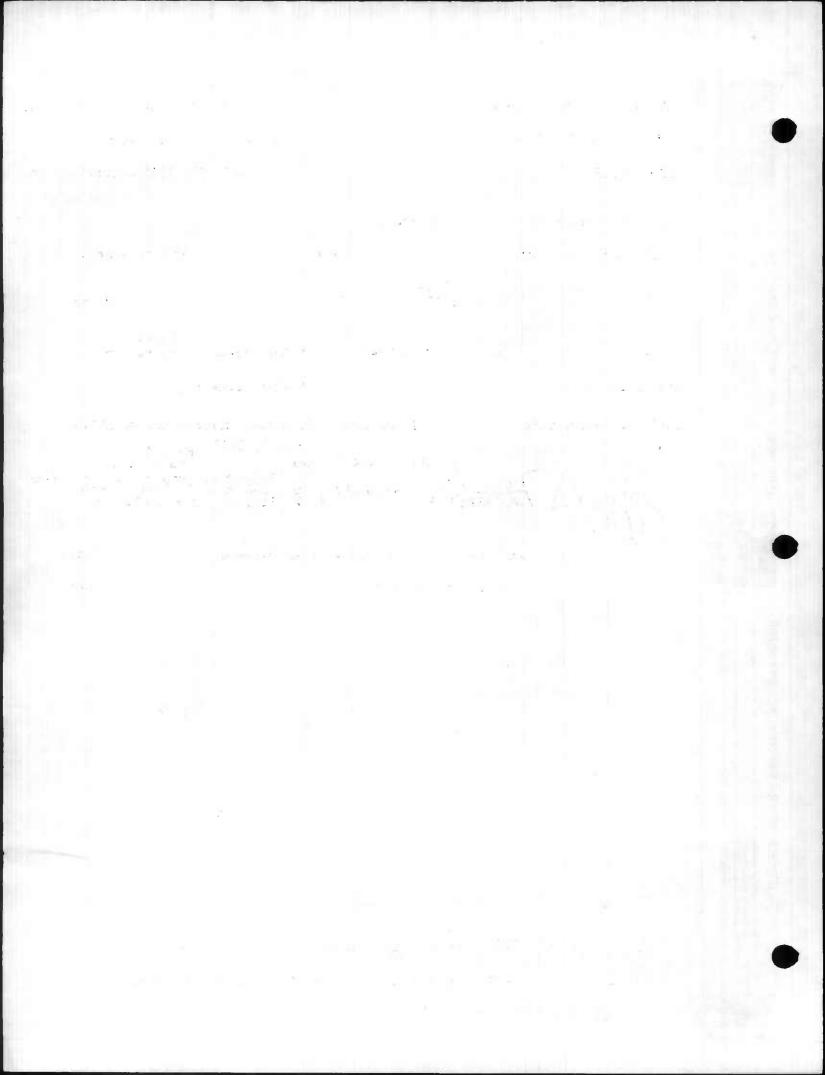
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Balt	pemit. Pag Depertment Important: if any Injury o		21. Signature of Funeral Service License	wholt-	- Do	Nama and Addre Onald V. OO Powde	ess of Fecility Borgward r Mill Rd	t Funer	al Home	, P.A.	nd 20705
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	Hospita 4 hours Funeral tely fille	edicai C	29a. Certifiar (Check only one) (Check only one) (Check only one)	clan: To the best of my knower: On the bests of axaminat and manner stated.	wladga, daath o lon and/or inva	occurred at tha tir stigation, in my o	ma, data and place, a plnion, daath occurr	and dua to tha co	causa(s) and ma data and place, a	nnar as stated and dua to tha	I. causa(s)
		Me	29b. Signature and title of certifier	STORE IMI	\	29c. Licens	e number		29d. Dele signed June	(Month, Day,	
	30		30. Name and address of person who com	pleted cause of daath (Itam	23a) (Type, Pr	rint)	1 200				
			James Brown, M.D. 31. Data filed (Month, Day, Year)	9707 Medica	1 Cente	r Dr.,	#300 Rock	ville,	Marylan	d 20850)
	Sta Registra		JUN 3 0 1998	32 Registrate Signal	- Handell	r.					

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State of Maryland / Department of Health and Mental Hygiene

				Otate of Ivie	iryiain		Certifica		Death	Vicinality	Reg. No.	8 2	216	515
	Physicia		1. Decedent's Neme (First, Middle, Last)						2. Dete of De Month	eeth Dey	Year	3. Tim	e of Death
	/Medic	ai	David Eugene	Lemon							8, 1998		12:	25 PM
	Examin	er	4a Facility Name (If not institution, give 11406 Brook Run	a second little of					4b. City, Town, or I			y of Deeth		
_			5. Social Security Number 6. Se		(In yrs. I	aet hirthr	(au) If Und	er 1 Year	Germanto			gomer	er	to or Foreign
L	Funeral Director			M 2□F	55	Yn	Month		Hours Min.	8. Date of Bi (Month, D July 3	0, 1942	Mass	achu	setts
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	he M	ecto	Maryland Montgomer 10e. Street and Number	У	Ger	mant		ip Code			10g. Citizen of	What Cour		
	with with	ă	11406 Brook Run Dr	170			101. 2	2087	6		United		•	
	Tre 22	nera	11. Meritel Stetus	12. Wes Decedent E	ever In U.	S.	13. Was Dec		lispanic Origin? (S en, Mexican, Puerl	pecify Yes or N		ce - Americ	an India	n,
20	permit. Pages 1 and 2 should be filled within 72 hours effer death with the Meryland Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show ery injury or other treumatic event, the Medical Examinations in confidence once.	Be Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☒ Yes 2 ☐ N If Yes, Give Yeer or Detes:	196 196	4-		ecity Cub		o Rican, etc.)	Speci	ock, White, White	etc. nite	
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,		-	30. Neme and eddress of person who co											
			Patricia L. Tomsk						ke #348,	Rockvi	lle, Man	ry1and	1 20	0852
	Stat Registra		31. Dete filed (Month, Dey, Yeer)	32. Registre	r's Signal	ture	Mandel	2						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decadant's Nama (First Middle Lest) 2. Data of Death 3. Time of Death **Physician** Month Joseph E. Liburd /Medicai 4b. City, Town, or Location of Death 28 1998 4c. County of Beath 7:02pm 4a. Facility Nama (If not institution, give straat and number) **Examiner** Community Doctors Hospital
7. Aga (In yrs. last Lanham Hrs. Prince George's Co. If Under 1 Yaar 8. Data of Birth (Month, Day Year) 9. Birtholace State or For Country)
Mar. 19, 1940 Saint Kitts 5. Social Security Number st birthday) **Funeral** 1**X**0 M 2□ F Days Hours 580-07-6816 Vrs 58 Director Usual Rasidance of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show Yas 2 No Director Christiansted, St. Croix Virgin Islands 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? must be 6 L Peters Rest Items 23a 00823 United States Completed by Funeral 12. Was Dacadent Ever in U,S. Armad Forces? 1 ☐ Yas 2 Ê No It Yas, Giva Year or Datas: 11. Maritel Status 13. Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Navar Married 2 Married 1□ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced **Black** the Medical 16a. Dacedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grade complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Control Quality Supervisor Oil Company Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 1 and 2 should be Health and Mental William Liburd Lucy Frances 19a. Informent's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) or other traces Virginia T. Liburd (wife) 6 L Peters Rest, Christiansted, St. Croix 00823 Baltimore, 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City of Town, Stete Christiansted. Pages 7-8-98 4 ☐ Donation 5 ☐ Othar (Specify) Kingshill Cemetery St. Croix, Virgin Islands 21. Signatura of Funaral Sarvica Licansaa 22. Nama and Addrass of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Qiomyosavcoma Immediata Causa (Final Lay disaasa or condition rasulting in daath) Examiner Dua to (or as a consequanca of): Examiner bunal-transit The law requires that the death certificate be executed pue Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants resulting in daath) Lest Dua to (or as a consaguance of): Box 68760. Physician/Medical the Dua to (or as a consequence of): 980 signed by the at 5 be detached for Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part i. Division of VItal Records, P.O. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara sutopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 this certificata 1 Yas 2 No 1 ☐ Yas 2 ☐ No i or Attending Physician: " after death. Director: After this certifica 25. Was casa rafarrad to medical axaminar? Be 26. Placa ot Daath (Check only ona) 2 Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA funerai Certification: 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima ot 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident in by the 6 Could not ba 3 Sulcida 28f. Location (Streat end Number or Rural Route Numbar, City or Town, Stata) 28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral C 29a. Cartifia 🖄 Certifying Physician: To tha bast ot my knowladga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signeture and title of certifie 29c. Licansa number 29d. Date signed (Month, Day, Year)

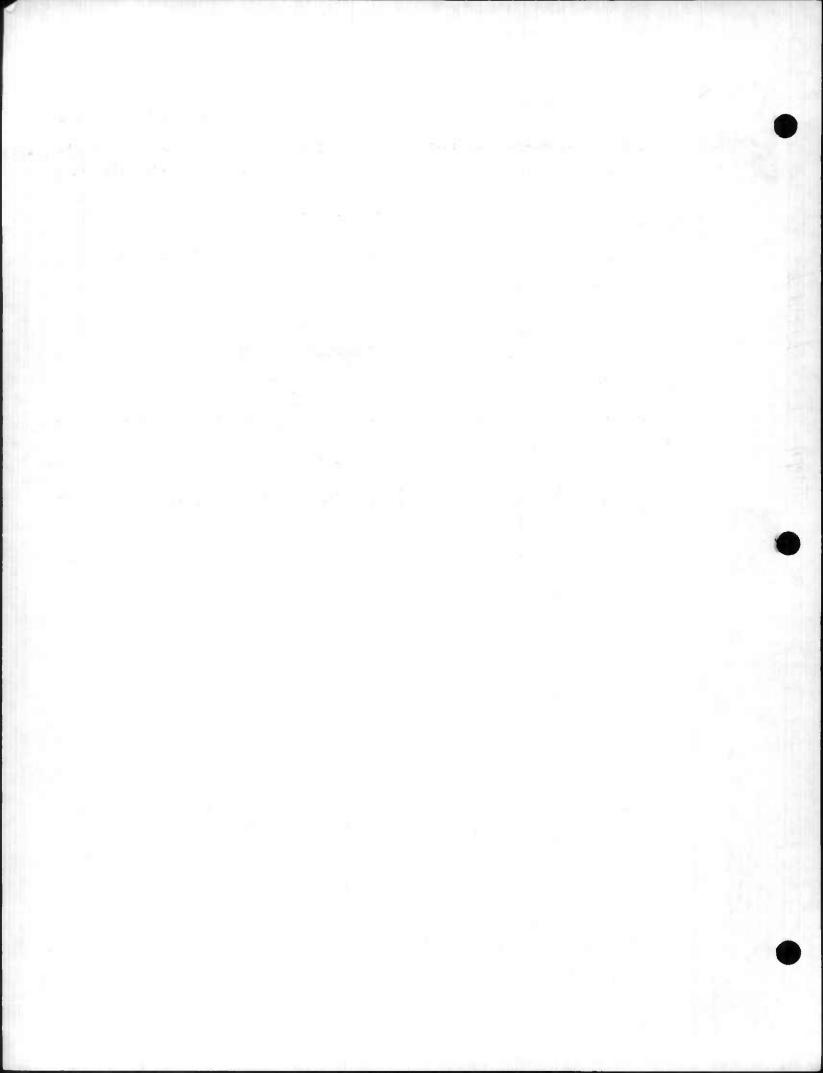
State Registrar

31. Data filed (Month, Day, Yaar)

JUL 0 2 1998 July Da

30. Name end addrass of person who complated causa of death (ftam 23a) (Type, Print)

32. Ragistrar's Signature
Julia Davidson-Rondelle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Samue 1 28, June Litwin 1998 8:58pm 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Devs Hours Min. (Month, Dey, 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Jan. 10, 1909 170 M 2□ F 051-09-6911 89 Yrs. Delaware Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5550 Tuckerman Lane 20852 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Furrier Fur Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Abraham Litwin Rose Moskowitz 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 115 Thrift St. Gaithersburg, MD Joel Verter/Son-in-Law 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 7/1/9801ney, MD Judean Mem. Gdns. 21. Signature of Funeral Service Licenses 22. Neme end Address of Facility Ives-Pearson Funeral Home 234. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, Applications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, Applications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, 22201 Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting In death) Lest eugaceteon Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by

Completed

Funeral

Director

r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at

72 hours after

I Hygiene.

permit Pages 1 and 2 should be filled a Department of Health and Mental Hygie Important: If item 27 is marked other?

Baltimore, Maryland 21215-0020

2

Physician/Medical Examiner Completed by 2 Be Certification: To To the Hospital within 24 hours at To the Fire Medical

Division of Vital Records,

death

25. Wes case referred to medical exeminer? 1 Yes 2 No

29a. Certifier (Check only one)

27. Menner of Death 5 Pending Investigation 1 Netural 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28e. Dete of Injury (Month, Day Year)

1 Minpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how Injury occurred

29b. Signature and title of certifier

Hospital:

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and manner as stated.

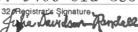
2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Dete signed (Month, Dev. Year)

6/29/98

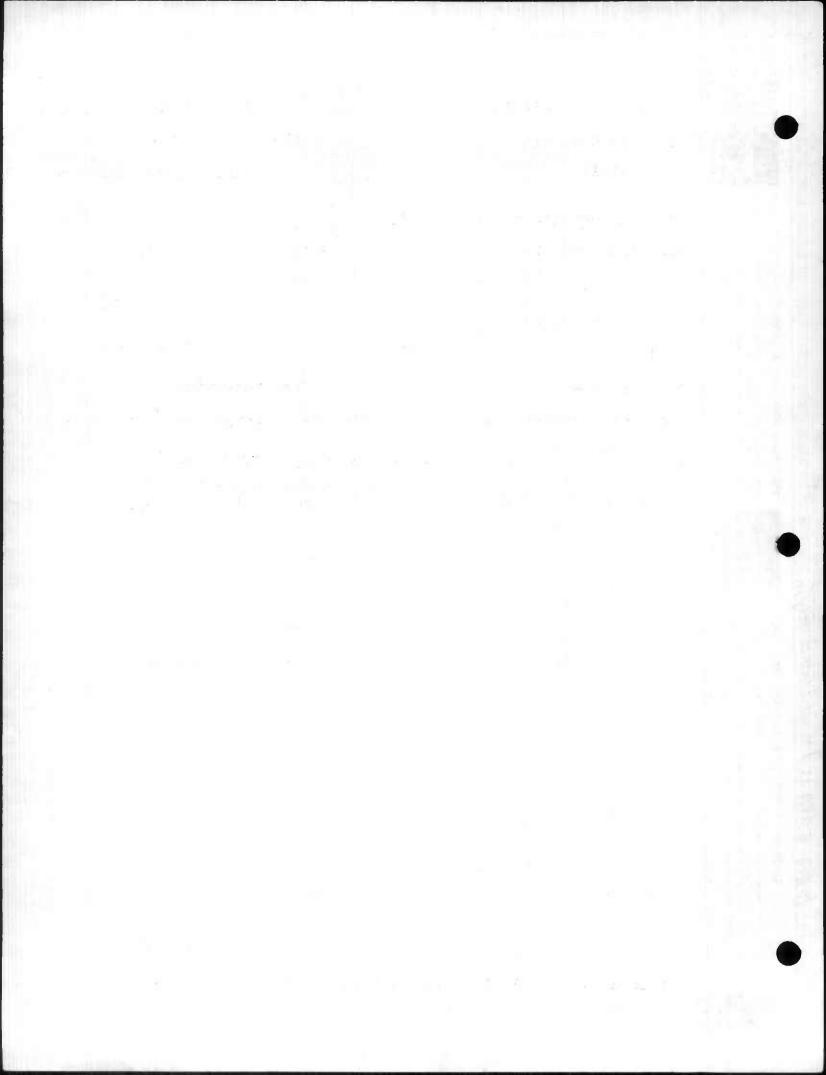
30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

Greta Bakshi, M.D. 9406 Old Georgetown Pike Bethesda, MD 20814

State Registrar



70



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Date of Daath Month **Physician** 8:00 PM Julius Livant June 29 1998 /Medical 4a. Fecility Nama (If not institution, give straat and number) 4b. City, Town, or Location of Daeth **Examiner** 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery 5. Sociel Sacurity Numbar If Undar 1 Yaar | If Under 24 Hrs. 6. Sax Birthplaca (Stata or Foraign Country)
 New York 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Yaar) **Funeral** 1**X**□M 2□ F Deys 083-32-3169 Yrs. Director 99 Sept. 17, Usual Rasidenca of Dacadan the Menyland 10a. Stata tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic evant, the Medical Examinar mant to notified at 10h County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No Directo Rockville Maryland Montgomery 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? death with 20852 6121 Montrose Road United States Funerai 12. Wes Decedant Evar in U,S. Armed Forcas? 1 M Yas 2 □ No If Yas, Giva Yeer or Datas: WW II Was Dacadant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumetic evant. 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: p Specify: 3 N Widowad 4 □ Divorcad White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Dacadant's Education 6b. Kind of Business/Industry Public Schools (Specify only highest greda complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Secondary Education 4 Teacher 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Be Esther Eicenbaum 2 Harry Livant 19e. informant's Name/Relationship (Type, Print) 19b. Malling Address (Streat end Number or Rurel Routa Number, City or Town, Steta, Zip Code) 38 Chestnut Street, #3, Morristown, NJ 07960 Judith G. Livant (niece) 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 Buriai 2 A Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Spacify) 6-30-98 Beltsville, Maryland Chesapeake Creamtory 21. Signatura of Funaral Sarvica Licansaa Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910 leen 23e. Pert1. Entar the disaasa, or complications that caused the daath. Do not enter tha mode of dying, such es cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Deeth **Physician** /Medical EREBRAL THROMBOSIS, ACUTE Immadiate Ceuse (Finel (WEEK diseesa or condition rasulting in death) Examiner Physician/Medical Examiner physician end the buriel-transit The law requires that the death certificate be executed Saquentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Diseasa or Injury that initioted events rasulting in death) Lest Due to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of): 98 ettending p 950 deteched Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown signed I Records, þ been si 24b. Wera autopsy findings eveilebla prior to complation of cause of daath? 24e. Wes en autopsy performed? Completed page 2 s certificate 1 Yas 1 ☐ Yas 2 ☐ No. Division of Vital or Attanding Physician: 25. Was casa raferred to medical exeminar? Be 26. Placa of Daath (Check only ona) 1 Yas 2 No Hospital: Othar: Certification: To 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient Nursing Home 5 Rasidanca 6 Other (Specify) this funeral 28e. Data of Injury (Month, Day Yaar) 27. Mahner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Natural 2 Accident 5 Panding Invastigation efter deeth.

Director: Af
d in by the fu 1 ☐ Yas 2 ☐ No 6 Could not be 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, street, factory, office building, alc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide filled in • Funeral [Hospital 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29e. Cartifiar To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and 188 29d. Deta signad (Month, Day, Year) Attending Physician

ROCKVILLE, MD 20852

30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print)

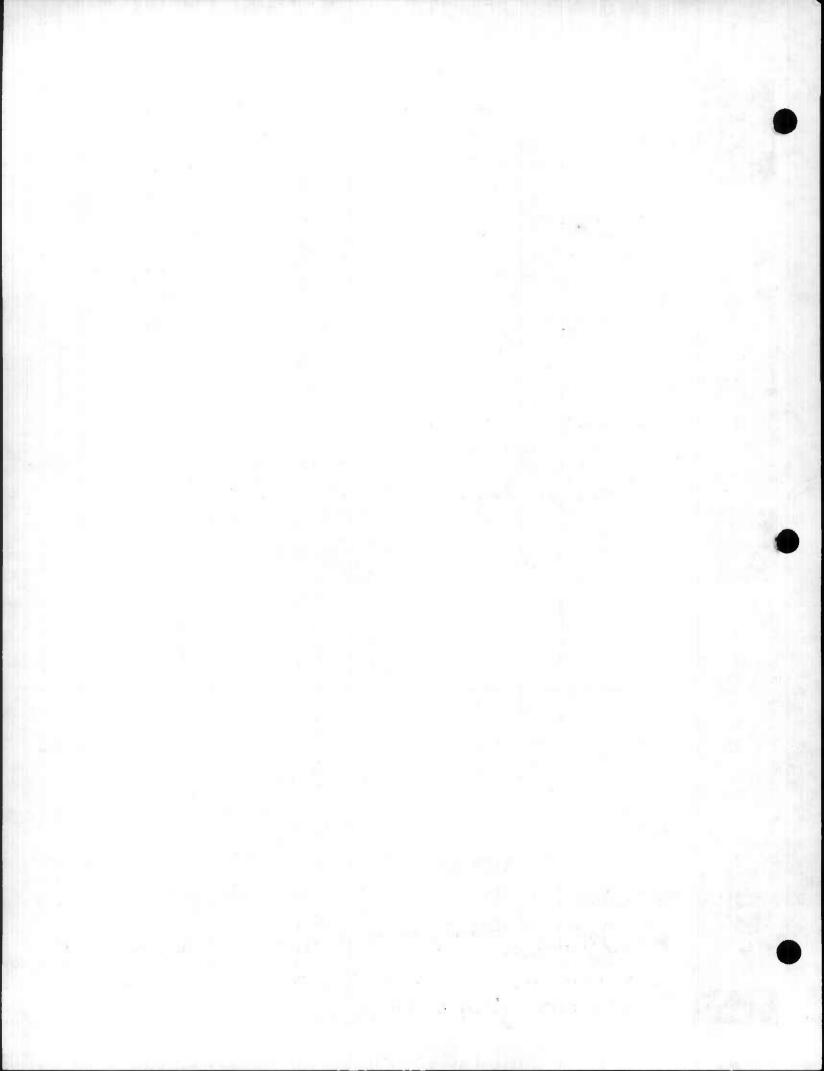
1998

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6121 MONTROSE

State Registrar 31. Deta filad (Month, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death Day 1998 June 28, Abe Lubarsky 6:40 AM 4a. Fecility Name (If not Institution, giva straet and number) 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Mooth, Pay, Year) | April 13, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York 1 M 2 □ F Months 80 119-01-3464 Usuel Residence of Dacedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6105 Montrose Road, #4207 20852 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 D(Yes 2 □ No If Yes, Giva WW I I 11. Marital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Never Marriad 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) Salesman Vacuum Cleaner 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Surname) Sam Lubarsky Anna Swing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 315 West 86th Street, New York, NY 10024 Ellen Lubarsky (daughter) 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-30-98 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha moda of dying, such as cerdiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Intarval Batween Onset end Death Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last

Physician /Medicai Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

r than "natural", or items 23s or 28s-f show

filed within 72 hours after

al Hygiene.

permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event

Baltimore, Maryland 21215-0020

cian/Medical Examiner

sician and bunal-transit physician the buna for use as 8 after death filled in by 24 hours

or Attending Physician: The law requires that the death certificate be executed

death.

To the Hosp within 24 ho To the Fune completely fi

Hospital

Division of Vital Records, P.O. Box 68760.

Es sential	y Try	personner to death but not rain	sulting in the underlying	cause given in Part I.	23b. Did tobac		ntribute to the cause of death
arteny	dis	wye		,	24a. Was an au performed 1 ☐ Yes	17	24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) No
25. Was cese referred to axaminer?				26. Place of I	Death (Check only one)		
1 ☐ Yes 2 No		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ I	OOA Other: 4 Nursin	g Home 5 Residence	6 □Oth	ear (Specify)
2 Accident	Pending Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how le		
3 ☐ Sulcide 6 ☐ 4 ☐ Homicide	Could not be determined	28a. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, St	t and Numb tate)	per or Rural Route Number,
29a. Certifier (Check only one)	artifying Phy ledical Exam	raician: To the best of my kno inar: On the basis of axamina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, data and place, in my opinion, death or	ace, and due to the cause courred at the time, data a	e(s) and ma and place,	anner as stated. and due to the ceuse(s)
29b. Signature and title of	certifier		2	9c. License number	29d. I	Date signe	d (Month, Day, Year)

MD

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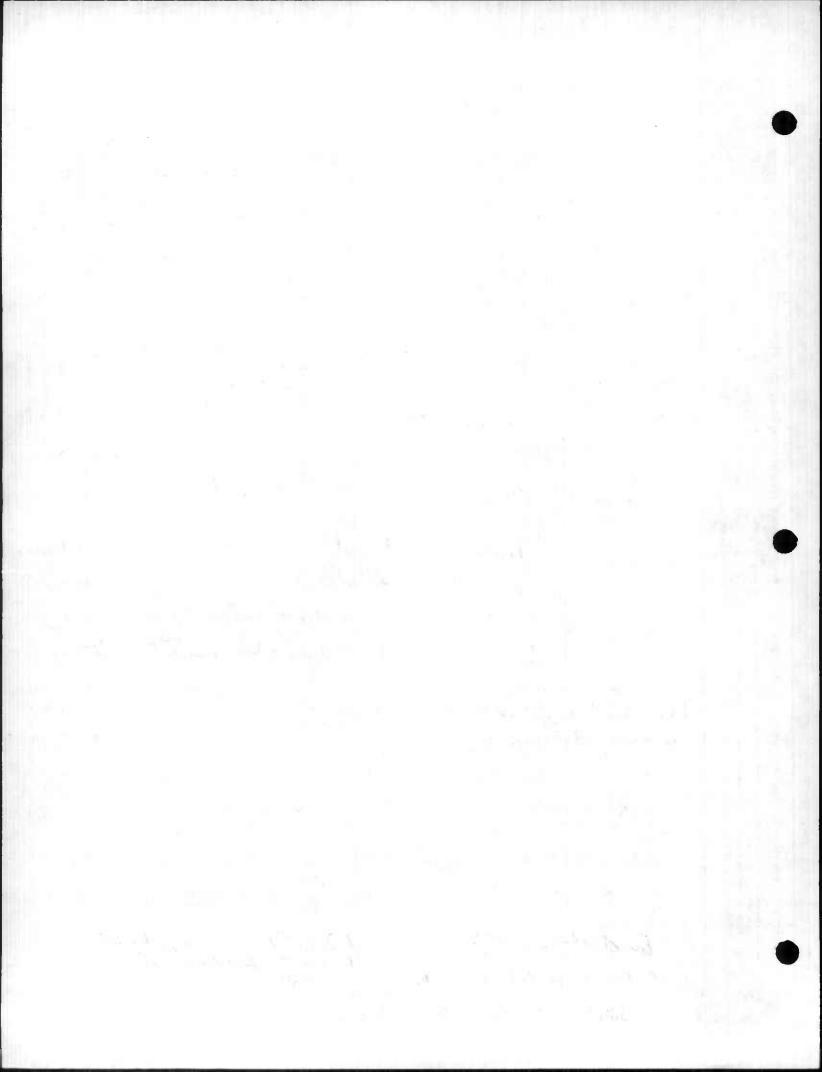
State Registrar

31. Date filed (Month, Day, Year)

Ruckvitte 105 Montrose Rd. 32. Registrar's Signatura

30. Nama and address of person who complated gausa of daath (Itam 23a) (Type, Print)

Olie Davids



Genevieve McLaird

Baltimore, Maryland 21215-0020

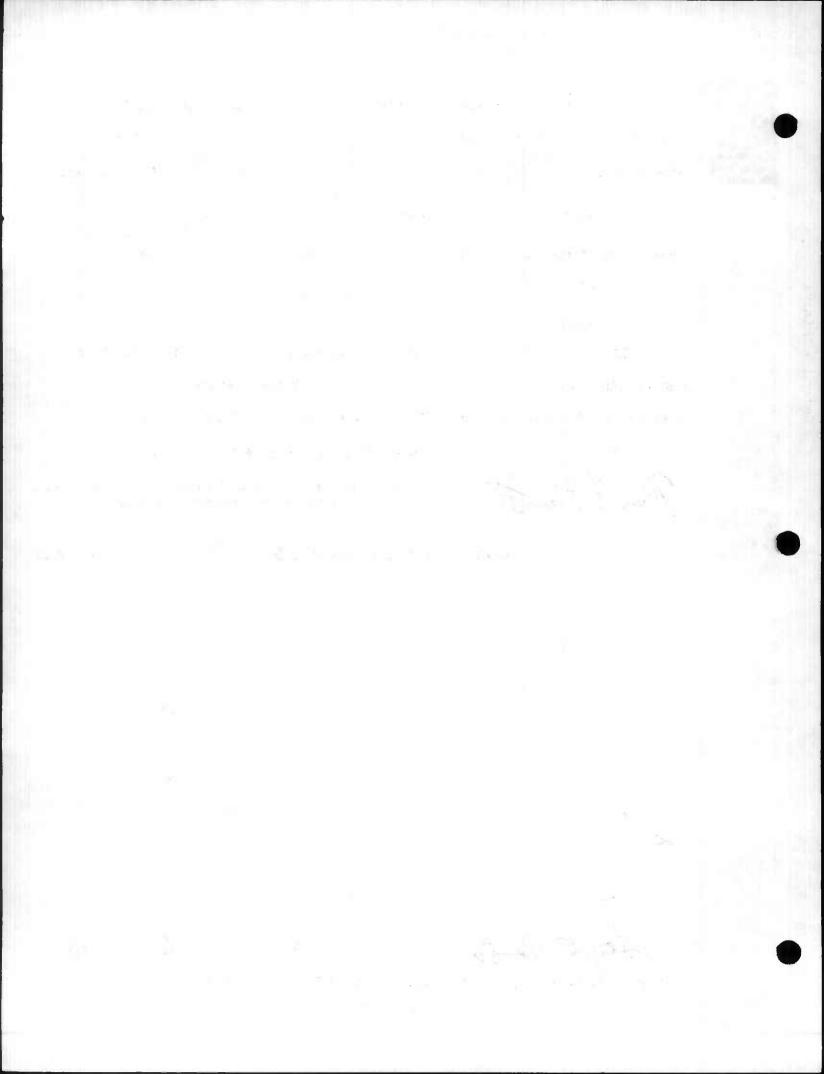
Division of Vital Records, P.O. Box 68760,

Certificate of Death 1. Decadant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death 30^{Day} **Physician** Month 1998 McLaird Genevieve Celeste June 5:30 AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8311 Diamond Back Cove Road Easton Talbot 5. Social Security Number If Undar 1 Year If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 1 M 2 F 78 Yrs. 065-16-2822 Director May 19, 1921 New York Usual Residence of Decedant the Maryland 10a, Sfata 10b. County in end Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner. Mall be notified at 10c. City. Town or Location 10d. Inside City Limits Director Md Talbot Easton 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Counfry? 8311 Diamond Back Cove Road 21601 USA Completed by Funeral death 12. Was Decedanf Evar in U,S. Armed Forcas? Was Dacedanf of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, afc.) 14. Raca - American Indian, Black, Whita, atc. 72 hours efter 1 Navar Married 2 Married 1 ☐ Yas 2 ☒ No If Yes, Giva Yaar or Datas: 1 ☐ Yas 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decadant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 salesperson/owner clothing store 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) . Pages 1 and 2 should be filt ment of Heelth end Mental Hyant: If item 27 is marked oth jury or other traumatic event Be Charles Hegerman (unknown) Irene 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Bell McLaird/husband 8311 Diamond Cove Road, Easton, MD 21601 20b. Placa of Disposition (Nama of cematary, crematory or other place)
Chesapeake Cremation Ctr. 6-30 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Ramoval from Stata Depertment of Important: If eny injury or 4 ☐ Donation 5 ☐ Othar (Specify) re of Funeral Service License 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison St., Easton, Md 21601 Pair1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** Immediata Cause (Final disaasa or condition rasulting in daath) /Medicai SA ESOP WA EUS 10 YES **Examiner** Dua to (or as a consaquance of): Examiner the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disaasa or Injury that Initiated events rasulting in death) Last Due to (or as a consequence of): Physician/Medicai Dua to (or as a consequence of): for use es signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings available prior fo complation of cause of daath? 24a. Was an autopsy performed' page 2 certificate 20 No 1 Yas 1 ☐ Yas 2 ☐ No si or Attending Physician: Ti s after death. I Director: After this certificat 25. Was casa refarred to medical examinar? Certification: To Be 28. Place of Death (Check only ona) Other: 4 Nursing Home 1 Rasidance 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA 1 Yes 25 No funeral 28c. Injury at Work? 27. Manner of Death 28d. Dascribe how injury occurred 1 Natural 5 Panding Invastigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral D Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifier (Check only one) To the Within 2 29b. Signatura and titla of certifia 29c. Licansa number 29d. Date signed (Month, Day, Year) 6-30-98 D01225 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) M.D., 509 IDLEWILD AVENUE, EASTON, MD 21601 STEPHEN P. CARNEY, 32. Registry 31. Data filad (Month, Year State JUN 3 0 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3 Time of Death Month Yaar **Physician** Annie Matthews Mae June 23, 1998 4:45 AM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico 5. Social Sacurity Number If Under 1 Year If Under 24 Hrs. 9. Birthplaca (Stata or Foraign Country) Virginia 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Days Hours Min 1□ M 2⊠ F **Yrs** Usual Rasidance of Dacadant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Director Accomack Mappsville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4280 Lankford Hwy 23407 United States Funerai 12. Was Dacedant Evar In U,S Armed Forcas? Was Decadant of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuben, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, White, etc. 1 □ Never Married 2 → Married 1 ☐ Yes 2 XNo If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 ☐ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) School System Teacher 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Louis Williams Melvianna Williams ပ 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Willie Matthews(Husband) 14280 Lankford Hwy. Mappsville, Va. 20b. Placa of Disposition (Nama of camalary, cramatory or other placa)
First Bapt. Cem. 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burlal 2 Cramation 3 Ramoval from Stata 6-27-98 Mappsville, Va. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama end Addrass of Facility 21. Signatura of Funarai Service Licenses Wharton Funeral Home Keth E. Whaton 22171 Wharton Rd. Accome
23a. Part 1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22171 Wharton Rd. Accomac, Va. 23301 Approximate Interval Between Onset and Death Immediata Causa (Final diseasa or condition rasulting in daath) Dua to (or as a consequence of): Saquentially list conditions, if eny, leading to immadiata causa. Entar Underlying Causa (Disaasa or injury that Initiated avants Dua to (or as a consequence of) aile Due to for es a consaguenca of) rasulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings evailebla prior to completion of cause of daath? 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to madical axaminar? 26. Placa of Daath (Check only ona) Hospital: Othar: 42 Nursing Homa 5 Residence 8 Othar (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Anatural 5 Panding invastigation

Funeral

Director

ns 23a or 28a-f shor

item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner my

Pages 1 and 2 should be filed within 72 hours efter onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or itei

Hygiene.

permit. Pages Department of Important: If it any injury or o

Physician /Medicai

Examiner

Baltimore, Maryland 21215-0020

death with the Maryland

Examiner Physician/Medicai by Completed Be 2

page 2 director. funeral Certification:

attending physician and for use as the bunel-tran requires that the death certificate be exec P.O. Box 68760, the signed by t Division of Vital Records, has certificete Hospital or Attending Physician: After this s after death. filled in by within 24 hours a To the Funeral D

6 Could not ba 4 Homicida 29a. Cartifian (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Accident

3 Suicida

28a. Data of Injury (Month, Day Year)

28a. Placa of Injury - At home, farm, streat, factory, offica building, atc. (Specify)

1 Yes 2 No

281. Location (Streat and Number or Rural Route Number, City or Town, Stata)

1 🕒 Cartifying Phyalcian: To tha bast of my knowladge, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated.

21804

29b. Signatura and titla of certifiar

29c. Licansa number D 29349

29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print)

William H. Robins, M.D.

1104 Healthway Dr., Salisbury, MD

State Registrar

Medical

31. Data filad (Month, Day, Year) JUN 2 9 1998



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Virginia Month Year Mason 30 1998 0605 June 4a Facility Name If not Institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (Stata or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 25 F Yrs. 212-72-0266 39 July 28,1958 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2X No Maryland Worcester Pocomoke City 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3675 Sheephouse Road 21851 USA 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Ricen, atc.) 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - Amaricen Indian, 11. Maritai Status Black White, etc. 1 Naver Married 2 Married 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housewife 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Ronald Edward Semke Bernis Lane Mister 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) DAvid Neil Mason Jr./Husband 3675 Sheephouse Rd., Pocomoke City, MD 21851 20b. Placa of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State First Baptist Cemetery 7/3/98 Pocomoke City, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funa_jal Sarvice Licensee 22. Name and Address of Facility Holloway-Melson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dylng, such as cerdiac or respiratory arrest, Approximately Approximate Interval Between Onset and Death Leukema Immediate Cause (Final disease or condition resulting in death) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Last Dua to (or as a consequenca of): Due to (or as a consequence of): 23b. Dtd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 2XNO 3 Probably 4 Unknown 1 Yes 24b. Ware sutopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) / Impatient 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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7 is marked other than "natural", or items 23s or 28s-f short traumstic event, the Medical Examiner must be notified at

permit. Pegas 1 and 2 should be flied within 72 hours efter to Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event.

Baltimore, Maryland 21215-0020

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Box 68760

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Division of Vital Records,

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Examiner Physician/Medical þ Completed Be Certification: To

Neturel 2 Accident

3 Suicida

29a. Certifier

4 Homicide

(Check only one)

signed by t peed hes d or Attending Fafter death. After Director: 24 hours a

> State Registrar

5 Pending

6 Could not be determined

investigation

28a. Date of Injury (Month, Day Year) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

1 ☐ Yas 2 ☐ No

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔀 Certifying Phystotan: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29c. Licanse number 29d. Date algned (Month, Day, Year)

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26278 Salush, MD

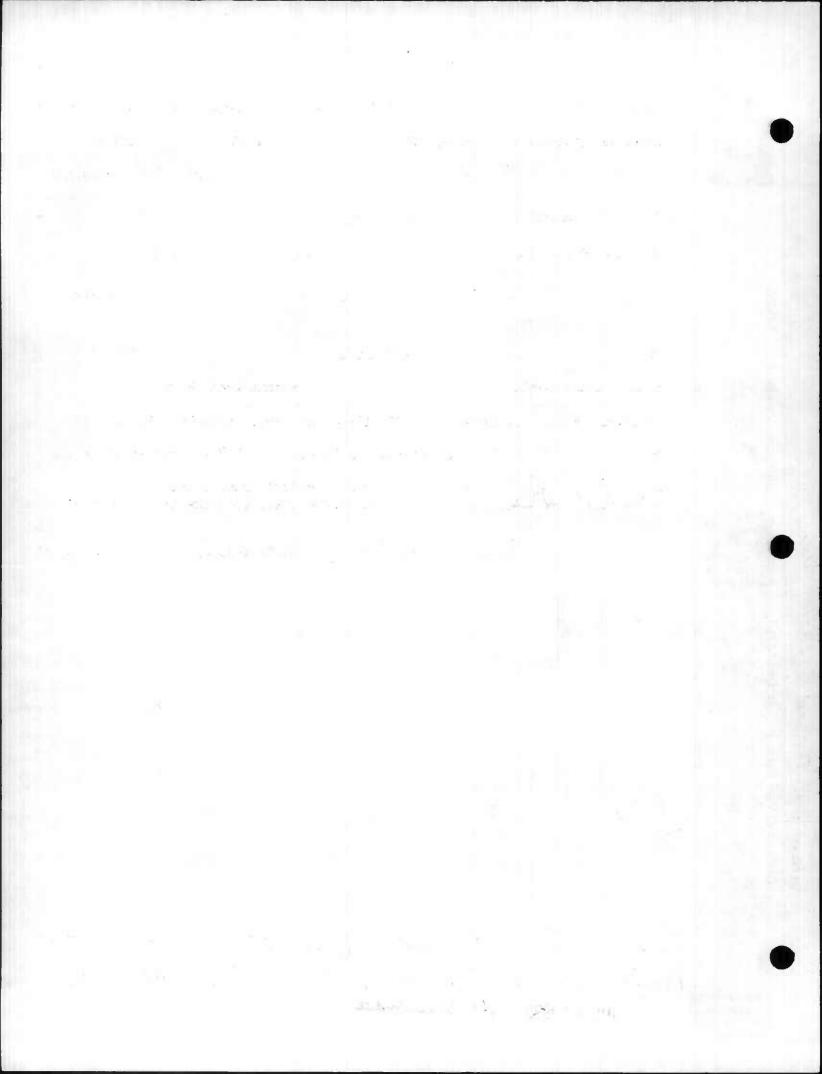
31. Date filed (Month, Day, Year)

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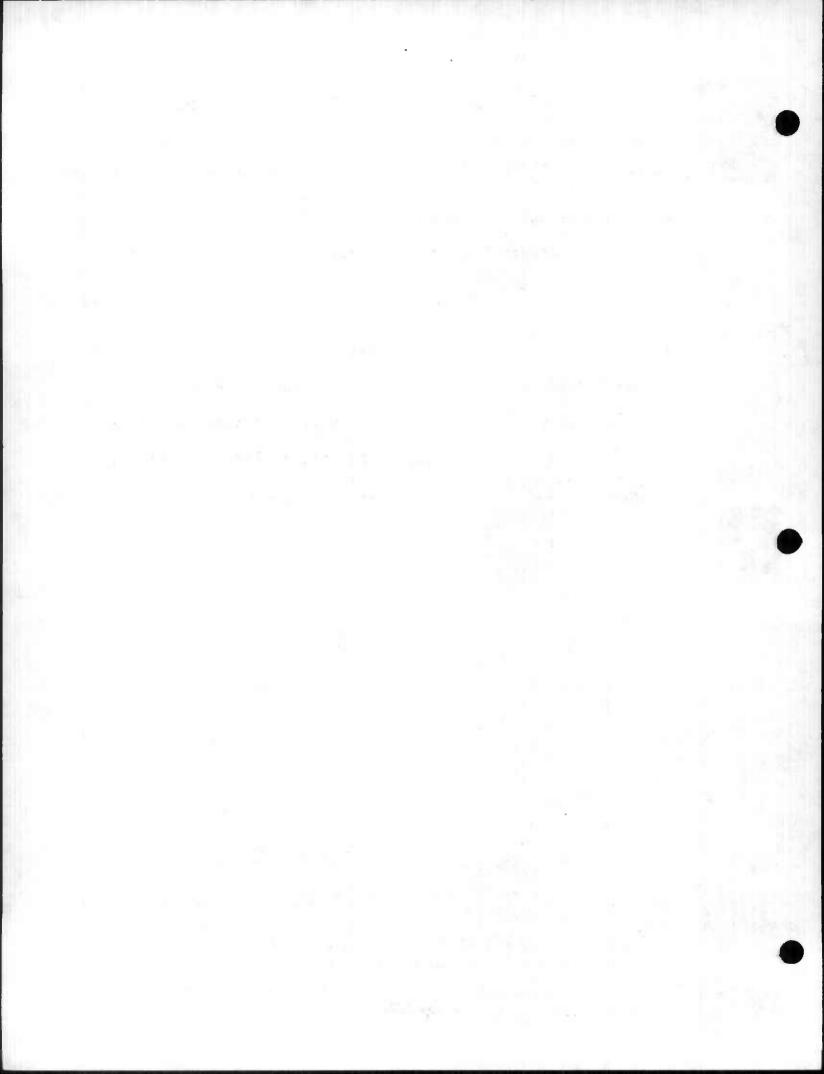
32. Registrar's Signature

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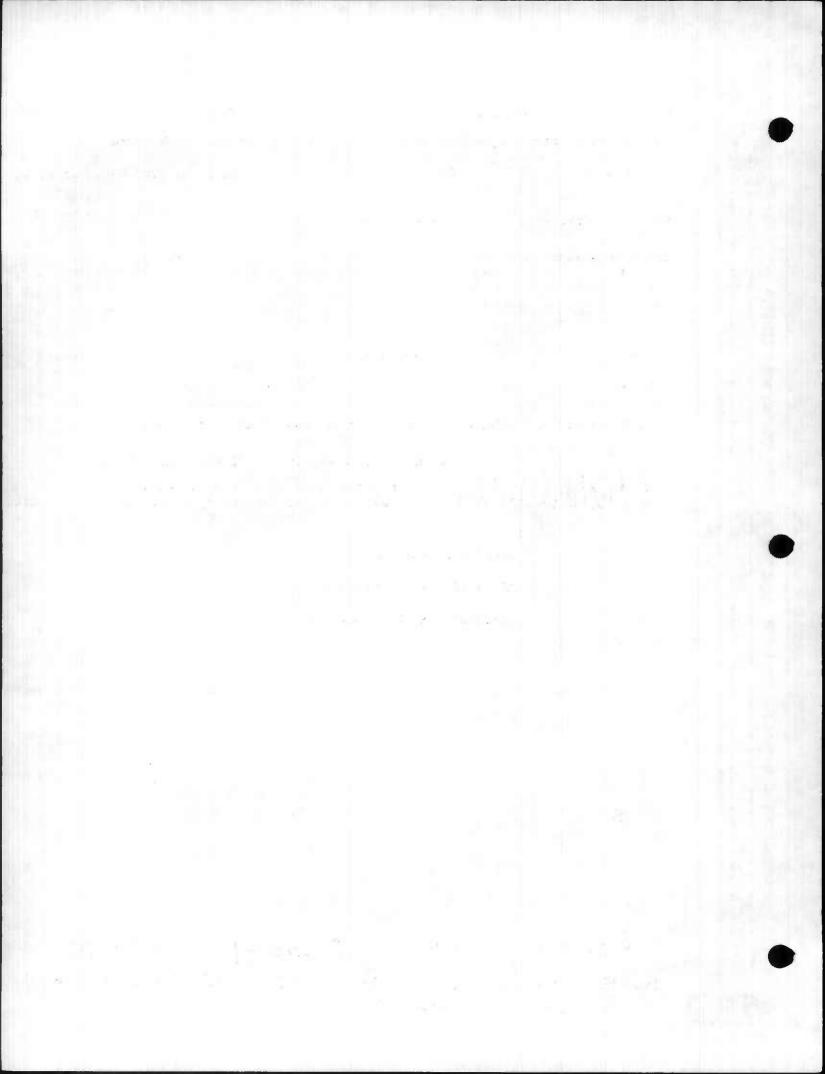
State of Maryland / Department of Health and Mental Hygiene

						Certificate of	Death	Re	g. No.	4:023
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ı	/Medi				DERIC	MAIER		JUNE 30	1, 1998	
Į.	Exami	ner	4a. Facility Nama (If not institution, given				4b. City, Town, or Lo	ocation of Death	4c. County of	
L		7	11063 GRAYS 5. Social Sacurity Number 6.5			nday) If Under 1 Yaar	BERLIN	O Date of Birth		ESTER
	Funeral Director			7. Aga (///	yrs. last birth	rs. Months Days		8. Data of Birth Month, Day	Year) 9.	Birthplaca (Stata or Foraign Country) WOFC N J
	yland		10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
	Maria Maria	ctor	MD. WORCEST	ER	BERLI	N				1 □ Yas 2 No
	if th	Director	10e. Street and Numbar			10f. Zip Coda		10	g. Citizan of Wha	it Country?
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	ar da	Funeral	11. Marital Status	12. Was Decedent Evar Armed Forces?	in U,S.	13. Was Dacedant of If Yas, specify Cul	Hispanic Origin? (Sp ban, Maxican, Puarto	ecify Yes or No- Rican, etc.)		Amarican Indian, Whita, atc.
21215-0020	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Haelth and Mental thygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, it a Medical Examinat must be notited at	þ	1 □ Navar Married 2 □ Marriad 3 ➡ Widowed 4 □ Divorced	1 (E¥es 2 □ No if Yas, Giva Year or Datas: W	W II	1 □ Yes 2 No			Specify:	WHITE
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2	2 should and Me Is mark eumatic	2	19a. Informant's Name/Ralationship (19h	Mailing Addrass (Strea	CHARLOT			to Zin Code)
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	Physician /Medical Examiner	ler	In the disassa, or combook, or heart failura. List only Immediata Causa (Final disassa or condition rasulting in death)	a. CORONA A	ey_		OCC LU	31	51,	Approximate interval Between Onset and Death
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Division of Vital Records,	aw requals been 2 should	Completed I						24a. Was an perform		Wara autopsy findings available prior to completion of causa of death?
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	To the Hospital or within 24 hours aff To the Funeral Di complataly filled in	edical C	29a. Cartifier (Check only one) 1 Certifying Ph	and dua to the cau ed at the time, dat	usa(s) and menna a and place, and	r es stated. dua to tha causa(s)				
	Withil Comp	×	29b. Signature and titla of certifier	-/-		29c. Licans	sa number	290	d. Data aigned (N	fonth, Day, Year)
			Darthy C.	Holyworth	Mie	1. 0	06241		07-01	Month, Day, Year) 1111, MD, 21763
			30. Nama and address of parson who	complated causa of death	(Itam 23a) (T	ype, Print)				2/7/-
	9	5	DOROTHY C.	HOLZWOZ	771,	M.D.	203 SNO	SW ST	SNOW H	ILL, MD, 63
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	Registr	ar	JUL 0 2 1998	c. Raind	Jan-Mark					



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Year Month **Physician** Mary E. 1998 McClosky June 12:45 AM /Medical 4a Facility Name (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Genesis Eldercare - Layhill Center Montgomery If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Funeral 1□ M 2 F 579-28-8253 90 Sept. 20, 1907 Washington, DC Director Usual Residence of Decadant Meryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County than "naturel", or items 23s or 28s-f show the Medical Exampler must be notified at 1 ☐ Yes 2 X No Director Montgomery Silver Spring the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 14400 Homecrest Road, #146 20906 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Giva 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced Yaar or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Educetion (Specify only highest grade completed) 18b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe any lojury or other traumatic avent BACs. 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Unknown Kieny Unknown Unknown 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Timothy McClosky / Grandson 15719 Haynes Road, Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cramation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Metropolitan Crematory 6/28/98 Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service License Brus 500 University Blvd, West, Silver Spring, MD 20901 dations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to cause on each line. Approximata Interval Between Onsat and Death 23a. Part1. Enter the disease, or compli shock, or heart failure. List only or **Physician** /Medical Immediate Cause (Final CARDIOPULMONARY ARREST disease or condition resulting in deeth) Examiner Due to (or as a consequence of). Examiner ADVANCED CARDIO DISEASE ician and buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) CEREBRAL VASCULAR ACCIDENT physician at the buriel Box 68760. Physician/Medicai Due to (or as a consequence of): 98 ed by the detached 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. o signed by t d be detact 1 Yes 2 No 3 Probably Wunknown ۵. Division of Vital Records. þ 24b. Were autopsy findings available prior to complation of cause of death? should Completed 24e. Wes an autopsy s certificata has b 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Attending Physician: funeral director, Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred After 1 Neturel 5 Pending 1 Yes 2 No ne Hospital or Attendi n 24 hours after death ne Funeral Director: A death. 2 Accident investigation the 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) filled in by 4 Homicide cal 29a, Certifier 16 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to tha cause(s) and mannar as stated. complataly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated. (Check only one) To the To the To the F 29d. Data signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number Rosie K Such 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 2415, MUSGROVE RD SILVER SPRING MD 20904 K. SINGH. 31. Dete filed (Month, Day, Year)
JUN 2 9 1998 State Registrar

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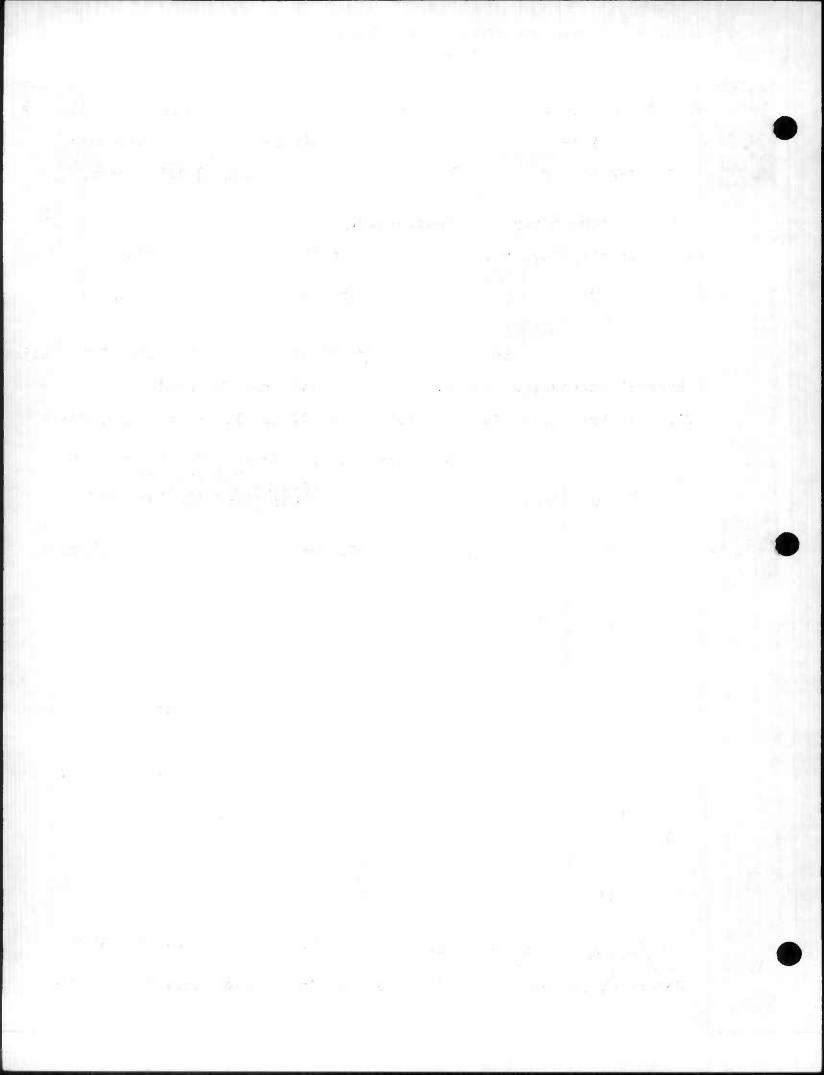
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month McDonald Maurice June 27, 11:05pm 1998 Joseph /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Gaithers Case of Birth (Month, Dey, Year)

House Deys Hours Min. Aug. 2, 1925 10331 Battle-Ridge Pl. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funerai** 1√2 M 2□ F Yrs 72 Director 030-14-6160 Mass. Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Gaithersburg Montgomery 10e Street and Number 10f. Zip Code 10a. Citizen of What Country? 10331 Battle Ridge Pl. 20879 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 ☐ No It Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 X No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "nany injury or other traumetic event, in thest Elementery/Secondary (0-12) College (1-4or 5+) 5+ Copy Editor Magazine Publication 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Russell Athenasius McDonald Walburga MacDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Virginia McDonald/Wife 10331 Battle-Ridge Pl. Gaith., M.D. 20879 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete July 2'98 Foxboro, Mass. 4 ☐ Donetion 5 ☐ Other (Specify) St. Mary's Cem. DeVol Funeral Home 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility 2222 Wisconsin CAVE 2000 N.W. Keorge Warner Bury 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting In deeth) Metastatic Colon Cancer 2 years Examiner Due to (or as a consequence of): Examiner physician and the burief-transit Sequentially list conditions, if eny, leading to Immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760. that the death certificate be Physician/Medical Due to (or as a consequence of) ettending p Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed peed 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case reterred to medical examiner? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 XResidence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion Director: / 6 Could not be determined 3 ☐ Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral Dir.
To the Funeral Dir. XCertifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end plece, end due to the ceuse(s) end menner steted. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 29, 1998 D32407 30. Name and address of person who completed/pause of death (Item 23a) (Type, Print) M.D. 9707 Medical Ctr. Drive Rockville, MD20850 Joseph M. Haggerty, 31. Dete tiled (Month, Day, Year) 32 Registrar's Signeture State JUN 3 0 1998 gillia Davidson Registrar

DHMH 16 Rev 6/95

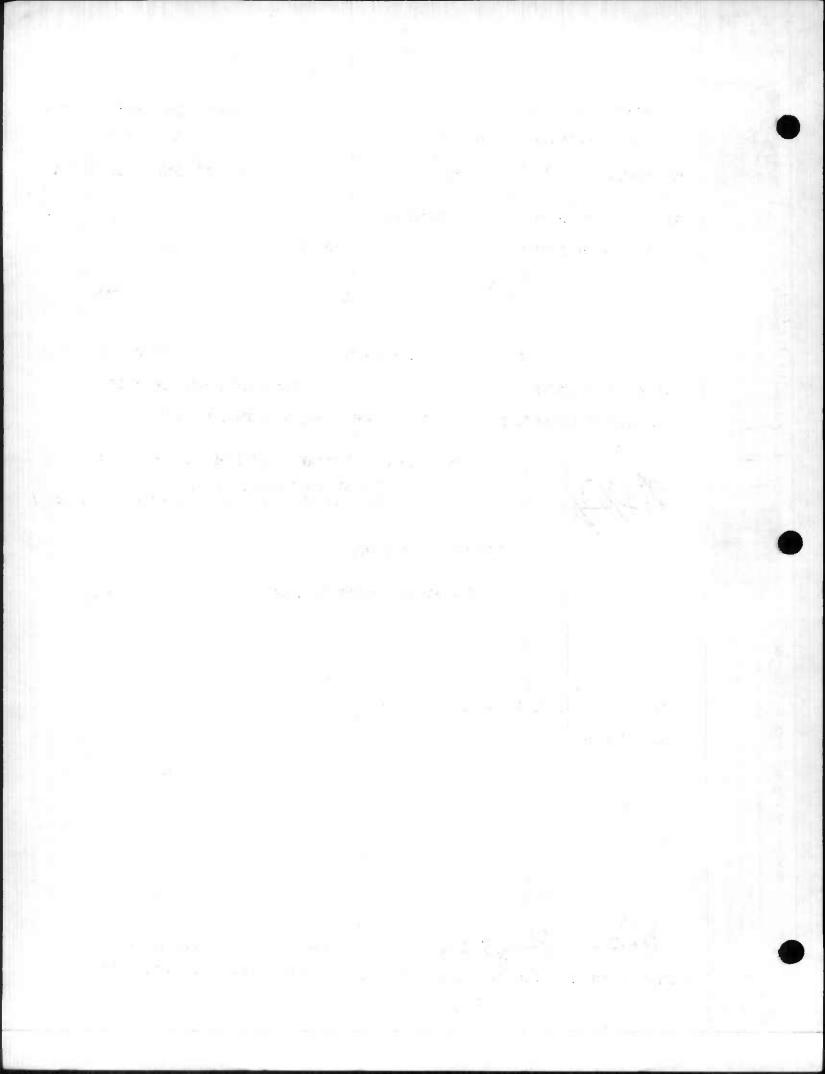


State of Maryland / Department of Health and Mental Hygiene 98 21626

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	D11-		1. Decedent's Neme (First, Middle, Las	t)					1	2. Dete of Dear	th	Vans	3. Time	e of Death
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	and **		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City,	Town or Lo	cation						Od Inside	e City Limits
	he Marylan 18a-f show offilied at	ector	MD MONTOME	RY	K	ENSING							1 🗆 Y	res 2XI No
	23a or 2	Funeral Director	3000 McCOMAS AV	ENUE			10f. Zip Code	0895		10g. Citizen of Whet Cor USA			itry?	
15-0020 72 hours after death with the Maryland "natural", or items 23a or 28a-f show social Examiner must be notified at		þ	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 ☐ Yes 2☐ if Yes, Give Yeer or Detes:		1	Wes Decedent of Yes, specify Co	uban, Mexican	tispenic Orlgin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) Specify:			14. Race - American Indien Bleck, White, etc. Specify: WHITE		
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ylan			JUCZAS MESKAUSK	AS					ANISI	AVA NA	RGELAVI	CIUS		
Mar			19e. Informent's Neme/Retetionship (T		19b. Mailing Address (Street a 7012 RIVER RO.							State, Zip	Code)	
	1 an Heali		20e. Method of Disposition	GHIEK)	20b. Pla	ce of Dispo	sition (Name of				20c. Location	City or To	wn, Stete	,
altimore,	0 0		1 ☐ Buriel 2 XCremation 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify,				netory or other p		6/2	5/98	ALEXANI	ORTA '	VA	
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Foreral Service Licens			TOMFORT CREMATORY 6/25/98 ALEXANDRIA VA 22. Name end Address of Fecility AFFORDABLE FUNERAL SERVICE 2230 GALLOWS ROAD #110 - DUN LORING, VA. 2							22027	
	Physician /Medical		23e. Pert1. Ente de de la comp shock, or hant failure de only de Immediete Ceuse (Finel					lying, such es	cardlec or	respiretory err	est,			mete Between nd Deeth
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_	n #	ner		CEDE				ETOTENO	237					
,0	e axecuted ian and urial-transi	Examiner	Sequentielly llst conditions, if eny, leeding to Immediate cause. Enter Undertying Ceuse (Disease or injury c.										EARS	
ox 68760,	aath certificate be axecuted attending physician and for usa as the burial-transit	n/Medical	thet initiated events resulting in deeth) Lest	d	Due to (or e	uence of):								
ω.	0 0	Physician	Pert II. Other significant conditions co	ntributing to death b	out not result	ing in the u	nderlying cause	given In Pert I.		23b. Did to	bacco use co	ntribute to	the cau	se of death?
P.0	es that tha da igned by the a be detached i	by Phy	SENILE INANITIO	N, RECURR	ENT P	HEUMO	NIA,			1 🗆 Y	es 2 No	3 Prol	bably 4	Unknown
Records,	aw requir s been s 2 should	Completed b	SEPTICEMINA							24a. Was e periori	en eutopsy med?	eve	ere eutop eileble pri mpletion death?	sy findings for to of cause
<u>س</u>	0 - 0	Son								1 □ Y	es 2 No	1 [Yes 2	2□ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was cese referred to medicel examiner?	Hospital:					of Deeth	Check only on	ne)			
o	\$ 00	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie		R/Outpetien	I SLI DOA				ence 6 Oth		y)	
on	fing After Tune	Certification:	1 Neturel 5 Pending 2 Accident investigation	(Month, De	Injury	W	ork? □ Yes 2 □ I		o. Describe III	ow underly occur	160			
Division	Attendir deat		3 Sulcide 6 Could not be 4 Homicide determined	eet, factory, offic	factory, office 28f. Location (Street end Number or Finding City or Town, State)				ber or Rure	Route A	vum <i>ber</i> ,			
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edicai (29a. Certifier (Check only one) 1	sician: To the best of the basis of end menner sta	edge, deeth n and/or inv	seth occurred et the time, dete end plece, end due r investigation, in my opinion, death occurred at the				due to the ceuse(s) and menner es steted. at the time, date and piace, end due to the cause(s)				
	To the within 2 To the comple	Me	29b. Signature end title of certifier	flan 0	6		29c. License number 29d. Dete signed 06–24–19					(Month, Day, Yeer)		
			30. Name and eddress of person who commartin C. SHARGEL	ompleted dayse of d	death (item 2	^{23e)} (Type, FARR	Print) LAGUT AV	E. KEN	SINGT			-		

State Registrar 31. Dete filed (Month, Dey, Year) JUN 3 0 1998

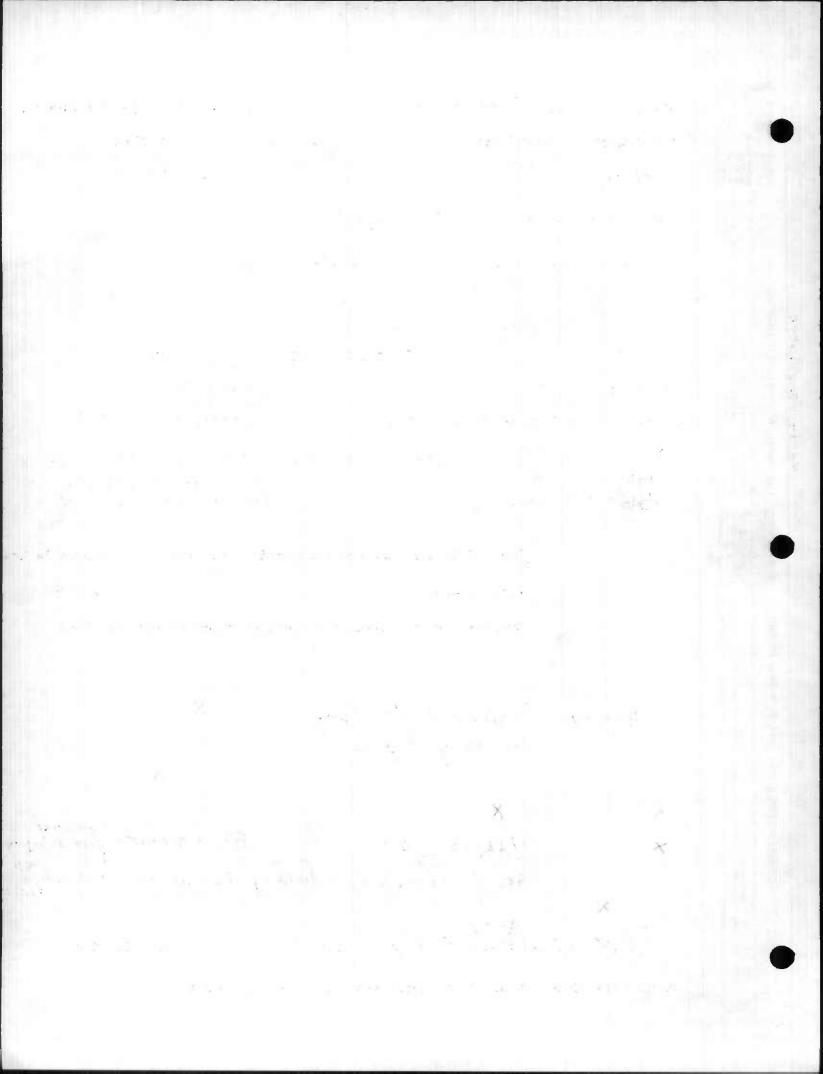




DHMH 16 Rev 6/95

	State of Maryland / Department of Health ar Certificate of Death	nd Mental Hygiene Reg. No	98 21627
	1. Decedent's Neme (First, Middle, Last)	2. Dete of Death Month Da	3. Time of Deeth
Physician /Medical	MARIE E. MCALLISTER	June 23	1998 7:00a.m.
Examiner		, or Location of Death 4c.	. County of Death
	The Memorial Hospital Easton 5. Social Security Number 6. Sex 7. Age (In vrs. lest birthday) If Un rily r If Un erily r	Control of the Contro	Talbot
Funeral Director		Min. (Month, Day, Year)	
filed within 72 hours efter death with the Maryland Vigolen. ther than "naturel", or items 23a or 28a-f show ent, its Macral Examinar must be notified at a Completed by Funeral Director	10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits
to Tan	MD. Caroline Federalsburg		1 ☐ Yes 2 ☐ No
ol, or items 23a or 28a-f show Examinar must be notified at by Funeral Director	10e. Street end Number 10f. Zip Code	10g. Cit	lizen of Whet Country?
al D	403 Routzahn Lane 21532		USA
*naturel; or items 23s rocal Examinar must leted by Funeral	11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F		14. Raca - American Indien, Black, White, etc.
by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Yes, Give Year or Detes:		specify: White
leted	15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use retired)	f working 16b. K	ind of Business/Industry
M art	Elementery/Secondary (0-12) College (1-4or 5+) 1 1		rpax
Be Co		Neme (First, Middle, Meiden	
o B	Merle E. Glessner El	izabeth Cou	lbourne
or other traumetic avent, the Media	19e. Informent's Neme/Relationship (<i>Type, P</i> nint) 19b. Meiling Address (<i>Street</i> end <i>Number</i> of	or Rural Route Number, City	or Town, State, Zip Code)
. H	Libby McAllister/Daughter 5821 Puckum Road	, Rhodesdal	e,MD. 21659
to M	20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece)	Dete 20c. L	ocation - City or Town, State
n'y	4 Donetion 5 Dother (Specify) Hillcrest Cemetery	5/27/98 Fe	deralsburg, MD.
important, in tent 2) as marked order uses any Injury or other traumatic avent, the Manager. To Be Comp	21. Signature of Funerel Service Licensee 22. Name and Address of Fecility	Williamson	FuneralHome
a	Oto The Control of th	Federalsbur	
sician	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart feilure. List only one cause on each line.	rdiec or respiretory errest,	Approximete Intervel Between Onset end Deeth
Medical caminer	Immediate Cause (Final disease or condition Right Subdural Hematoma with Bra	in Contusion	Approx 24 hi
	resulting In death) Due to (or es e consequence of):		
in and interest Examiner	■ b. Fall Injury		One day
the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Einter Underfying Lyponton division and Antonia		
dical E	Couse (Disease or Injury c. Hypertensive and Arterioscieroti	c Cardiovascu	lar Dis. Years
	resulting in deeth) Lest Due to (or es e consequenca of):		
been signed by the elemining planning by should be detached for use as letted by Physician/Mer	d		
alcia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco	use contribute to the causs of death?
etached for use as I Physician/Mec		1)X(Yes 2	No 3 Probably 4 Unknown
b b	HISTORY CAPOLIO ENGLA FLEXE CHOMY		I
page 2 should	History Carotidendartexectomy Caronary bypass	24a. Wes en euto performed?	psy 24b. Were eutopsy findings eveilable prior to completion of cause
N Q	y y		of death?
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Be	examiner?	f Deeth (Check only one)	
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fical	3 Suicide 6 Could not be 28e. Pleca of Injury - A home) ferm, street, factory, office	28f. Location (Street et	nd Number or Revel Route Number,
dint	4 Homicide building, etc. (Specify) 403 Routz Ahn Lanc Federalshe	Chy of Town, Stell	LARE Federalbun
completely filled in by the funeral director, page Medical Certification: To Be Com	29e. Cartifier (Check only Check ieca, and due to the cause(s	e) end menner as steted. 2/43	
completely filled in by the funeral di Medical Certification: To	end menner steted. 29b. Signature and title of certifier 29c. License number	29d. Da	ate signed (Month, Day, Year)
8	Del a Short, m.D, D06804		une 6, 1998
	30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)		
		MD 01601	
	David Allan Stout, M.D. 219 S. Washington St., East	on, MD 21601	
State Registrar	David Allan Stout, M.D. 219 S. Washington St., East 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture July - 1°98 July Javidson-Randave	on, MD 21001	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Courth **Physiclan** Month HAROLD CLEVELAND MARRINER JR. 5, 1998 July /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 109 S. Eighth St. Denton Caroline If Under 1 If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 100M 2 F Yrs Director 216-74-5315 Oct. 2, 1930 Maryland Usual Residence of Decedent with the Manylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumetic event, the Medical Examiner must be notified at Maryland Caroline Denton 1 Yes TO No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23a 109 S. Eighth St. 21629 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, Bleck, White, etc. 11. Maritai Status Peges 1 end 2 should be filed within 72 hours after on ont of Heelth and Mentel Hygiene. nnt: if item 27 is marked other than "natural", or ite 1 Yes 2 No if Yes, Give Year or Detes: 15 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2√2 No Specify: White by Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unknown disabled lifetime 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Harold C. Marriner Sr. Marie Tanburg Marriner 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 s Depertment of Heelth an Important: if item 27 is 1 any injury or other trau Ralph Bramble 203 Maple Ave. Box 505, Ridgley, MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Stevensville Cemetery 7/7/98 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licansee 22. Name and Address of Felling Fenbein Fun. Hm, P.A. Greensboro, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner physician end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): for use es P.0. Part II. Other aignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown signed b Records, by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? peed page 2 hes certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. injury at Work? 5 Pending Investigation 14 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medicai 29a. Certifier 🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

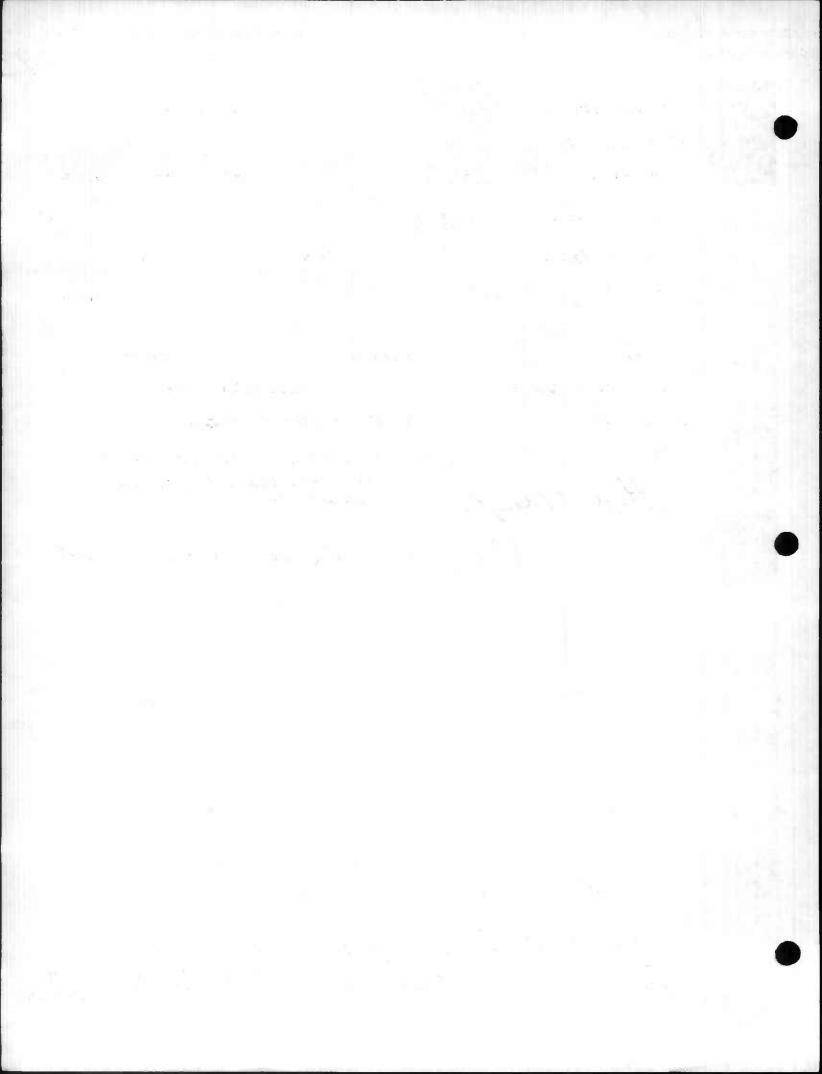
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- 6

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32. Registrar's Signature

chia Davidson



Registrar

Radentz

31. Date filed (Mont) (14), Yar) 4 1998

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State Registrar

31. Dete filed (Month, Day, Year)

29b. Signature and title of certifier

JUL 1 4 1998

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

MALIK MD

32. Registrar's Signeture who Davide

20311 LAPPANIS

29c. License number

D44996

BEONS BORD MD

29d. Date signed (Month, Day, Year)

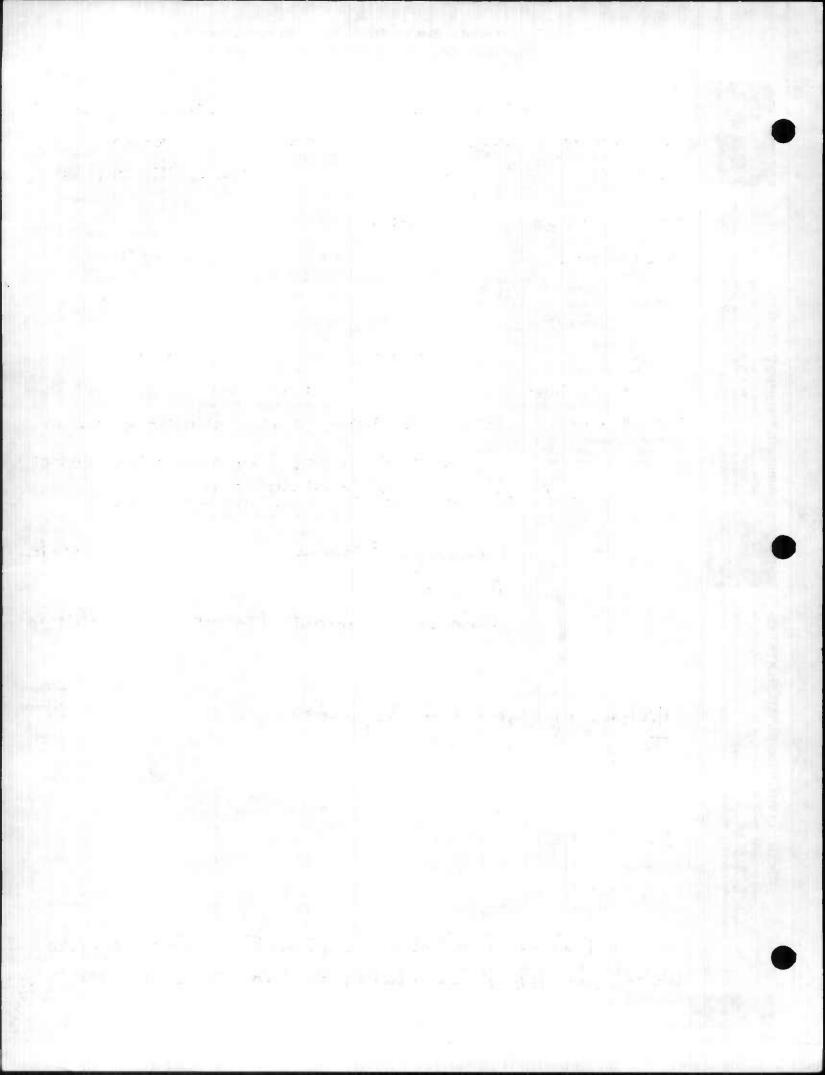
July 1, 1998

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		Certificate of Death	Reg. N	. 30 2163	31
	Decedent's Name (First, Middle, Last)		2. Date of Death Month D	ey Year	of Death
Physician /Medical	Lila B. Palm	er			O PM
Examiner	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death 4	c. County of Death	
	Montgomery General Hospital	Olney		Montgomery	
eral	5. Social Security Number 6. Sex 7. Age (In yrs. lest b	Months Devs Hours Min.	(Month, Dey, Yeer	9. Birthplace (Stete Country)	or Foreig
ctor	3/9-22-0/25 " 8/	Yrs.	Oct. 19, 1	1910 Michigan	
	Usuei Residence of Decedent 10a. State 10b. County 10c. City, Tox	wn or Location		10d. Inside (City Limit
5					s 2 X N
ect	Maryland Montgomery Burton 10e. Street and Number	1SVILLE 10f. Zip Code	10o. C	itizen of What Country?	
Director				ited States	
era	3415 Greencastle Road 11. Maritel Stetus 12. Was Decedent Ever in U.S.	20865 13. Wes Decedent of Hispanic Origin? (Spir Yes, specify Cuban, Mexican, Puerlo		14. Race - American Indian,	
Funeral Director	Armed Forcea?		Rican, etc.)	Biack, White, etc.	
by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: White	
P	15. Decedent's Education 166	a. Decedent's Usuel Occupation	16b.	Kind of Business/Industry	
Be Completed	(Specify only highest grede completed) Elementary/Secondary (0-12) Coilege (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ing		
EO	12	Office Clerk	Sta	ate of Michigan	n
e G	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Meide	n Sumeme)	
10	William H. Lavery	Eleanor	Bacon		
·	19e. Informant's Name/Relationship (Type, Pnnt) 19	9b. Mailing Address (Street end Number or Run	ral Route Number, City	or Town, Stete, Zip Code)	
		922 Blackbriar Street			03
once. To Be Completed by	20e. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	of Disposition (Neme of lery, cremetory or other place)	Date 20c. I	Location - City or Town, State	
5-	4 Donetion 5 Other (Specify) Ches	apeake Crematory 6	-29-98 Bel	tsville, Maryl	and
once.	21. Signeture of Funeral Service Licensee	22. Name and Address of Facility			
8	Cler A. Kapp	Rapp Funeral Servic 933 Gist Avenue, Si		g MD 20910	
	23a. Part1. Enter the disease, or complications thet caused the deeth. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such es cerdiac	or respiratory errest,	Approxima Interval Be	ate
ın	Shoot, of Healt failule. Elsi only one cause on each mile.			Onset and	d Deeth
al	Immediate Cause (Final disease or condition	- tdima		1 W-	eck
er	resulting in death)	consequence of):			
ine i	Angina				
Cam		a consequence of):	2 0	20	
E E	Sequentially list conditions, if any, leading to immediate cause. Enter UnderlyIng Cause (Disease or Injury	a consequence of):	riture	chri	mi
edical Examiner	that initiated events resulting in death) Last	a consequence of):			
5	d				
Completed by Physiclan/I				1	
ysi	Part II. Other eignificant conditions contributing to death but not resulting	in the underlying ceuse given in Part I.		co use contribute to the ceue	
P.	History of Myreadel	Infanction	1 Yee	2□No 3□Probably 4	Onkno
d b	History of Myocardial	0	24a. Was an aut	topsy 24b. Were autopsy	v finding
ete	Temporal Anten ti	2	performed?	evailable prior	or to
DE L				of death?	-1/
ပိ			1 ☐ Yea	200 No 1 ☐ Yes 20	LXNo
Be	25. Was cese referred to medicel examiner?	Othor	th (Check only one)		
1-1	TUTES 2000 12 Inpatient 2 LEH/C	Jutpatient 3LI DOA 4LI Nursing Ho	ome 5 Residence 28d. Describe how in		
lon	1 Neturel 5 ☐ Pending (Month, Day Year)	. Time of 28c. Injury et Work? M 1 Yes 2 No	200. Describe now in	ary occurred	
Cal	3 Suicide 6 Could not be		28f Location (Street)	and Number or Rural Route Nu	ım <i>ber.</i>
erti	4 Homicide determined 289. Piece of injury - At nome, building, etc. (Specify)	ium, suod, iudory, omos	City or Town, Ste		
edical Certification: To	29a. Certifier Cartifying Phyalcian: To the best of my knowledge	ne death occurred at the time date and place	and due to the causei	(s) and manner as stated	
dica	(Check only 2 Medical Examinar: On the basis of examination a one))(s)
Medical Certification: To Be Com	29b. Signeture end title of certifier	29c. License number	29d. D	Dete aigned (Month, Day, Year))
	William Tilling	la D45285	Ju	ne 28, 199	18
	20 Name and address of pages who applied a suite of death (the con-	(Tuno Print)		7 . 7 .	
	30. Name and address of perison who completed cause of death (Item 23a WF Ninaa, 1811)	Phillip Dr, Suite	= 212,0	long, Md	208
State	31. Date filed (Month, Dev. Year) 32. Registrar's Signature			0'	
istrar	31. Date filed (Month, Dey, Year) 32. Registrar s Stonature	-Nandall			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 2 | 632 Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 1325 PEARCE HIROC M 26 1998 JUNE 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth BARK WASHINGTON ACCOUNTST HOSPITCH TAKOMA MONTGOMERY 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthdey) 76 Yrs. 422-16-8395 June 15,1922 Virginia Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 1 Yas 2 No TAKOMA Park Md. MonTgomery 10e. Street end Number 10g. Citizen of Whet Country? GranT Ave. 302 U.S. A. 14. Race - American Indian, Bieck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Noves 2 November 19 Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WhiTe 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) N.I.H - U.S. GOV'T. LAB Tech 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pearce HamilTon Eugene Lucille 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10313 Parkman Rd. Silverspring, Md. 20903 Karen Lynn Sheppard (Doughter) 20b. Place of Disposition (Nama of cametary, crametory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from Stete 6/29/98 Riverdale, Md. Chambers Cremetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Chambers Funeral Homes, P.A. 5801 Cleveland Ave - Riverdale, Md. 20737 DOMOS 2 la. Part1. Enter the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Onset end Deeth Immediate Ceuse (Finel disease or condition rasulting in deeth) ARTEGUOSCUSRATIF CANDIOURSCULAR OLSOBE Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequance of) Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yee 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings eveileble prior to completion of cause of daath? 24e. Was en eutopsy performad? 2 N No 26. Plece of Deeth (Check only one)

Physician /Medical **Examiner**

ò

any injury

Physician

· /Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

þ

Completed

with the Maryland

death

filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Haaith and Mental Hygiena. Important: If item 27 is marked other than *

Saltimore, Maryland 21215-0020

Physician/Medical Examiner USB BS

that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

attanding physician and for use as the burial-trans ò Completed certificate has Mospital or Attending Physician:
24 hours after death.
 Funerel Director: After this certifice Be Certification: To

25. Was case referred to medical exempiner? Hospital: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Yes 2□ No 1 Inpatient 28 ER/Outpetient 3 DOA

27. Manner of Daath 28a. Deta of Injury (Month, Day Year) Natural 5 Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide 4 - Homicida

28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify)

MO

28c. injury et Work?

1 Tyes 2 No

28f. Location (Streat and Number or Rurel Route Number, City or Town, Steta)

28d. Describe how injury occurred

OME

29a. Certifij (Ched one) 29b. Signe

🖂 Certifying Phyaician: To the best of my knowledga, daath occurred at tha tima, data and place, end due to tha causa(s) and manner es stated Madical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number 015236 29d. Data signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)
CAPL I. WALBOUS, MO. 11125 POCKULUS PIKE, POCKULUS, MO 20852

State Registrar

Medical

31. Date filed (Month, Day, Yeer) 1998

32. Registrer's Signature

Guiden Randelle

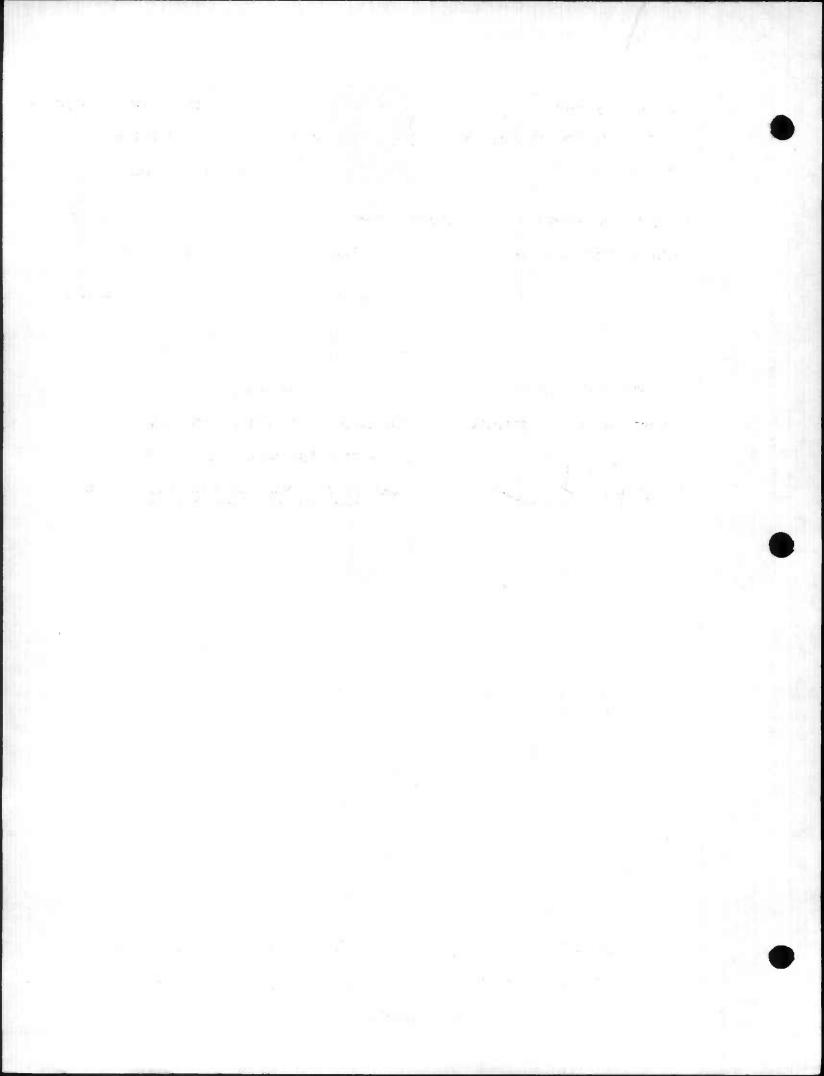
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					- St	ale of iv	arylar		tificate of	Death	Mental Hy	Reg. No.	3 2	1633
	Physici /Medic		1. Decedent'a Nam	Permut							2. Date of De June	28 Day 199	8 ^{Year}	3. Time of Death 2:20 am
	Examir		4a. Facility Name (If not institution, g						4b. City, Town, or OLNEY	Location of Deel		y of Death	7
	Funeral Director		5. Social Security N 577-48-		Sex 1 M 2		ge (in yrs. 87	last birthday) Yrs.	If Under 1 Yeer Months Days		8. Dete of Bi (Month, Di December	orth ay, Year) er 21,19	9. Birthp	niace (State or Foreign try) NEW YORK
	and		Usual Residence of 10a. State	Decedent 10b. County			10c. Cit	y, Town or Lo	cation				1	0d. tnside City Limits
	h the Maryland r 28a-f show	tor	MARYLAND	MONTGOM	ERY			LVER SE						1 XYes 2 No
	or 28s)irec	10e. Street and Nu	mber					10f. Zip Code			10g. Citizen of		•
	ath with	rai	3701 INT	ERNATION	AL D	R. #6	05		20906			UNITED	STATI	ES
Maryland 21215-0020	72 hours after death with the Maryland netural', or items 23a or 28a-f show dired Examinet rout be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Men 3 🛣 Widowed	ied 2☐ Married	1 E	es Decedent med Forces: Myes 2 ☐ Yes, Give ear or Dates:	?		Vas Decedent of Yes, specify Cub	Hispanic Origin? (pan, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	Special	ce - Americ ck, White, y:	
5-0	netural',	eted	(Spe	15. Decedent's	Education	pleted)		16a. Deced	lent's Usual Occu kind of work done	pation during most of wo	orking	16b. Kind of B	usiness/Inc	Justry
121	within 72 hours liene. rthan "netural", the Medical End	Completed	Elementary/Seco	ondary (0-12)	Co	ollege (1-4or	5+)	LAWY		ed)		LAW		
PC.	office office office office	Be C	17. Father's Name	(First, Middle, La						18. Mother's Na	ame (First, Middle	, Maiden Sumai	ne)	
ylar	Marrial Marrial arked o	ToB	(Unkı	nown) P	ermut			_		(Unkn	own)			
Mar	12 sho 12 sho 18 ma resum		19a. Informant's N			,				t and Number or F			, State, Zip	Code)
	o 1 and 2 si // Health and Hem 27 is r		EDWARD H		S	TEPSON			BAUER I sition (Name of	DR. ROCKY	VILLE, M	D 20853 20c. Location	- City or To	wn State
Baltimore,	Page ment of mnt: If it ury or		1 📆 Burial 2 4 □ Donation	Cremation 3	(4)	al from State		emetery, cren	netory or other pla	GARDENS				Wil, Olde
Bal	permit. Pa Departmen Important: any Injury ans		21. Signature of	meral Service Lip	6nsee	2	/	DA		ess of Fecility -GOLDBERG VILL PIKI				
	THE RESERVE		23a, Part1, Enter shock, or hea	ne disease, or co	mplication ly one cau	s that cause se on each i	the deat	h. Do not ente	er the mode of dy	ing, such as cardie	ac or respiratory a	rrest,	20052	Approximate interval Between
	Physician /Medical		Immediate Cause	Final		1) N	1	1. (7				i	Onset end Deeth
	Examiner		deease or condition resulting in death)			frence		YOCAL OT AS A CONSEQ		INFAR	CTION		1	36 Hours
	per ties	niner			b									
	tificete be execut ig physician and as the burial ma	Examine	Sequentially list co if eny, leading to in cause. Enter Unde Cause (Disease or	nditions, nmediate			Due to (o	r aa a conseq	uence of):					
,09289	ysicia	edical	Cause (Disease or that initiated events resulting in death)	5	C		Due to (o	r as a consequ	uence of):					
	death certificete be eme e attending physician a of for use as the burial		resulting in death)	Lest	d								į	
Box	death certifications at the transfer of the tr	Physician/M	Part It. Other etgnit	land andition	oostelbusti	an to double b		. Maria da Abarra		tials to Date 1	OOL DIA	A-1-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-		
P.0		hys		sta te	^			ulang in the ur	idenying cause gi	ven m ran i.		Yes 20(No		the cause of death?
	es tha igned be del	P		576 TC		unce,		-						
of Vital Records,	law requires that the as been signed by th 2 should be detache	Completed					<u> </u>				24a. Was	an autopsy ormed?	COL	ere autopsy findings allable prior to mpletion of cause death?
R	The law ata has page 2	Com									10	Yes 25 No		Yes 2□No
Vita		Be	25. Was case refer examiner?	red to medical	114 2-144						eath (Check only	one)		
of		5	1 ☐ Yes 252 27. Manner of Deat		Hospite	. Date of Inju		ER/Outpatient	1 3LI DON		Home 5 Res	how injury occu		1)
ion	Attending F r death. bctor: After by the funer	tion	1 ⊠Natural 2 ☐ Accident	5 Pending Investigati		(Month, De	y Year)	Injury	28c. tnju Wo	ork?]Yes 2 □ No	200. 5 950109	now injury occu	160	
Division	or Attending Ph ifter death. Director: After th in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 286	Place of the	ury - At ho	ome, ferm, stre	et, factory, office		28f. Location (Street and Num. wn, State)	ber or Rura	il Route Number,
٥	Ital or A					building, or	c. (opecii)	<i>''</i>			Ony or Yo	m, State)		
	To the Hospital or Attent within 24 hours after deat to the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)	1E Certifying F 2☐ Medical Ex	miner: O	To the best n the basis o nd manner st	examinal	wledge, death tion and/or Inv	occurred at the ti estigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
		Σ	29b. Signeture and	title of certifier					29c. Licen			29d. Date signe		
	15		20 No====================================	pan 1	<u> </u>	- 10	7)	00-1 77	ν:	>>45		June	. 40	,1710
			Name and addr	1- HENJ	Complete	cause of c	34((OLAn	volumed (COURT, S	WITE 20	o, an	EY, M	, 1998) 2083Z
	Sta Registr	- 1	31. Date filed (Mon	IN 2 9 19	98	32 Registr	ar's Signa	ture / Ande	N.					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Sophia Emily Pisanko June 24, 1998 1:20 PM 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Suburban Hospital Bethesda Montgomery If Under 1 Yeer If Under 24 Hrs. Months Devs Hours Min. 5. Social Security Number Birthpleca (Stata or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) 1 ☐ M 2 🗓 F Months Deys Yrs May 3, 1923 75 145-12-3806 Trenton, N.J. Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 Yes 2 No Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 11840 Farmland Drive USA 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Give Yeer or Detas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Merried 2 Merried 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Educational Adm. Aid 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Walter Zudnak Helen Slugajski 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Henry J. Pisanko/Husband 11840 Farmland Dr. Rockville, MD 20852 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) Dete 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete St. Hedwigs Parish Cem June 30'98 Ewing Township, N.J. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatoro Funerel Servica Licensaa 22. Nama and Address of Fecility DeVol Funeral Home 2222 Wisconsin Ave Washington, D.C. 20007 un or complications that caused the death. Do not enter the mode of dylng, such es cardiec or respiratory arrest, List only one ceusa on each line. Approximate Interval Between Onsat and Daeth Immediate Cause (Finel disease or condition resulting in deeth) 48 Due to (or es e consequence of): 1164 Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of deeth? 1 Yes 2 10 3 Probably 4 Unknown Mything 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy performed? complation of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 28. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 27. Manner of Deeth 28c. Injury et Work? 28b. Time of

Physician /Medical Examiner

Examine

Physician/Medicai

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Certification:

edical

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

the Merylend

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Example mortified any boose.

physician and s the bunal-transit as 980 ed by the a Deen certificate has irector, page 2 page

The law requires that the death certificate be axecuted ۵ Records, or Attending Physician: director Director: After this To the Hospital of within 24 hours af To the Funeral Di completaly filled li

PISANKO Division of Vital

31. Date filed (Month, Dey, Yeer)

1 Neturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature end title of certifier

29c. Licanse number

I Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred at the time, dete end pleca, end due to the cause(s) end menner steted. 29d. Data signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

0 33584

1 Yes 2 No

30. Name and addrass of person who completed cause of deeth (Item 23e) (Type, Print)

· now : +2, lavt: 4 MB 5

1201 Sevan Locks &d. Rockville no

State Registrar

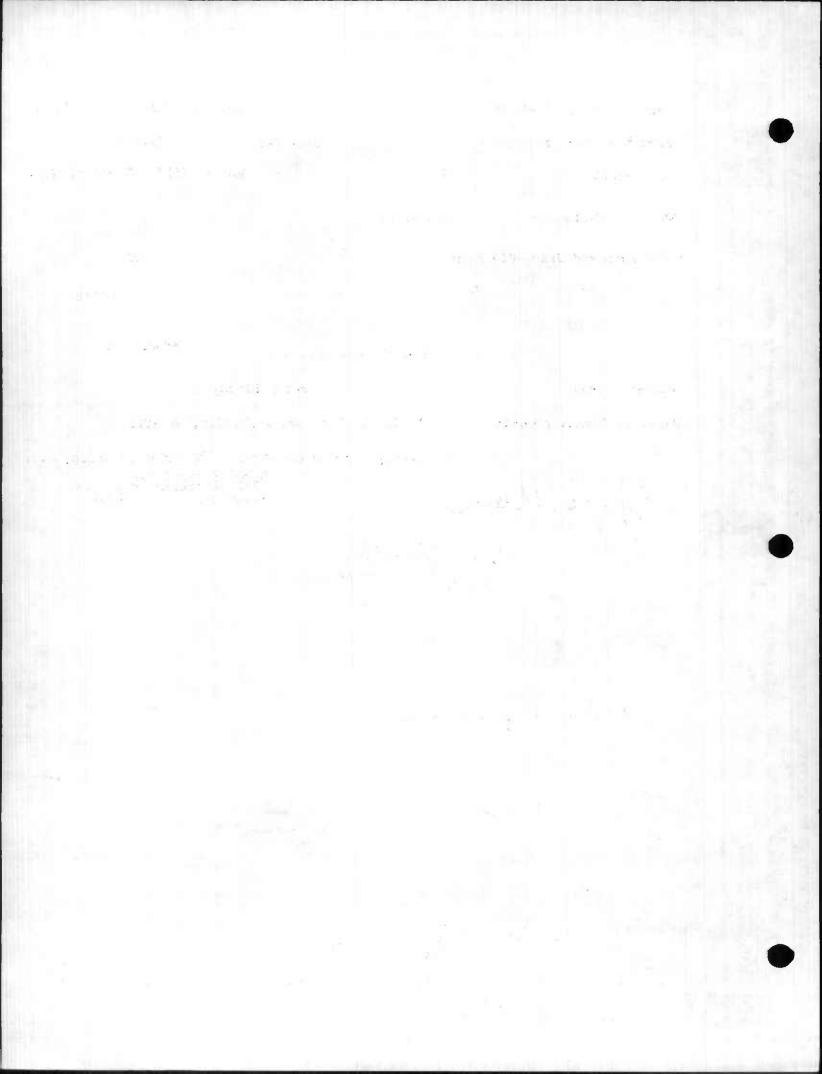
JUN 3 0 1998

5 Pending investigation

6 Could not be determined

32. Registrer's Signeture Let Deviden

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 23b per M.D G-761 7/24/98 reb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Deeth Dey 29 Yaar 98 Month 10:14 An 6 PATRICIA A. ROHRBACH 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, give street end number) Atlantic General Hospital Berlin Worcester If Under 1 Year If Undar 24 Hrs. Birthplece (Stete or Foraign Country) 5. Sociel Security Number 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Deys Hours Min. 1 ☐ M 2 X F 174-30-5960 Yrs. 60 8/1/37 PA Usuei Residence of Dacedant 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Berks Shillington 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 212 North Miller St. 19607 USA 12. Wes Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - Amarican Indien, Bleck, White, etc. 1 ☐ Yas 2 🔀 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry Eiementary/Secondery (0-12) Coilege (1-4or 5+) Own Home 12 Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) Leon W. Ostroski Amelia U. Winkleman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert R. Rohrbach/Husband 212 North Miller St. Shillington, PA 19608 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Steta 20e. Method of Disposition 1 XBuriai 2 ☐ Cramation 3 ☐ Removei from Stete Pleasant View Cemetery Sinking Spring, PA 7/3/98 4 □ Donetion 5 □ Other (Specify) 22. Neme end Address of Fecility Burbage Funeral Home Berlin, MD 21811 108 William St. usad the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximete Intervei Between Onsat end Deeth Immediata Ceusa (Final CZNUR year UNG diseesa or condition resulting In deeth) Due to (or es e consequence of) Sequentielly list conditions, if any, leeding to immadiate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Dua to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 12 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to complation of cause of death? 24a. Wes an autopsy 2 17 No 1 Yes 2 No 1 Yes 25. Wes cese referred to medicel exeminer? 26. Pieca of Deeth (Check only one)

Physician /Medical Examiner

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injury

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Directo

Funeral

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Completed

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r than "natural", or items 23s or 28s-f show

with the Meryland

death v

permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural, or ite

Baltimore, Maryland 21215-0020

ettending physician and for use as the bunal-transit the signed by ti peen hes certificate this

thet the deeth certificate be executed

The law requires

Box 68760

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Records,

Division of Vital or Attending Physician:

Physician/Medical Examiner þ Completed Be 2 27. Menner of Deeth Certification:

edicai

: After this funeral hours after death. I Director: A To the Hospital or A within 24 hours after To the Funeral Directompletely filled in b.

> State Registrar

6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as stated 2 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. (Check only one) 29b. Signature and title of certifier

5 Pending

investigetion

1 Yes 2 No

1 Naturel

2 Accident

1 Impatient

28e. Dete of Injury (Month, Dey Year)

29c. License number

2 ☐ ER/Outpetient

28h Time of

3D DOA

28c. Injury et Work?

1 Yas 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Hospitai:

(Thur

31. Dete filed (Month, Dey, Year)

32. Registrar's Signeture win Davidson

JUL 0 2 1998

Manager and the property of the

Little or all pass after the pass of the control of

State of Maryland / Department of Health and Mental Hygiene

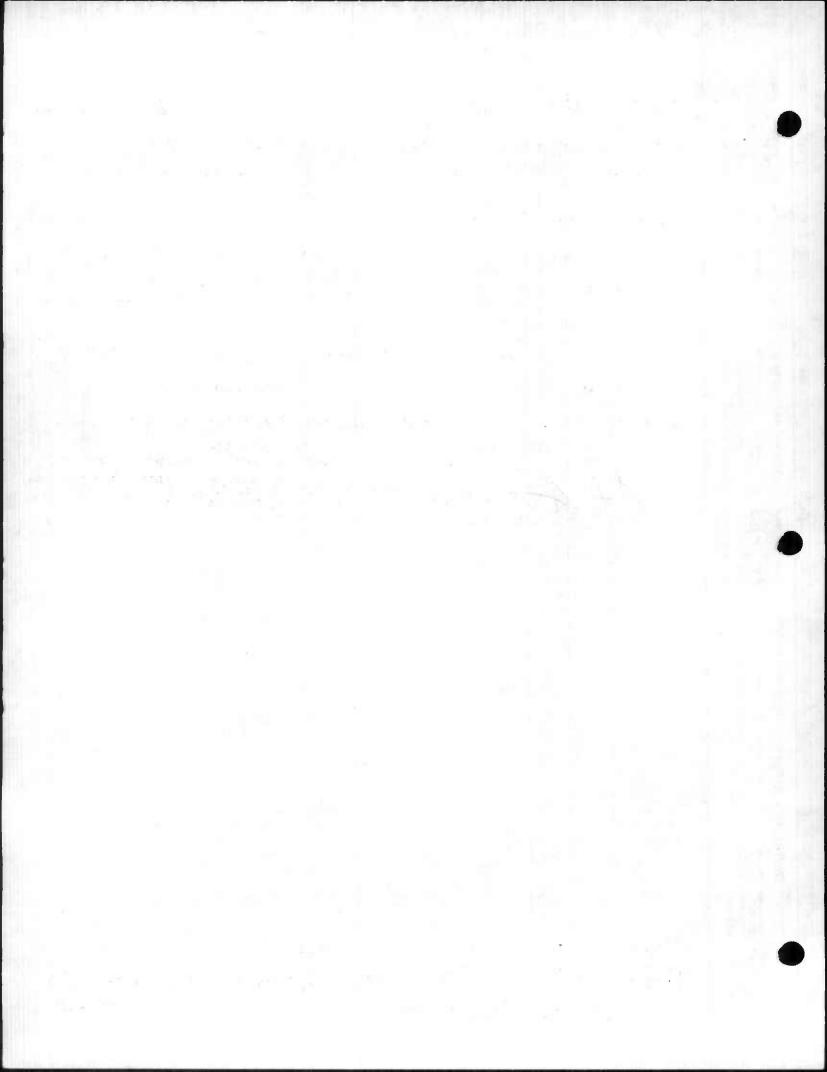
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month N. Najanna acanna. 20 98 /Medical 4a. Facility Neme (if not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Stagnes MURSING 4 Kehab Clicott (
If Under 24 Hrs. Center If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Deys Hours 027-30-6743 Yrs Director 78 August 15, 1919 India Usual Residenca of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at Director 1 ☐ Yas 2 No Maryland Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 238 6131 Morning Calm Way 21045 India Funeral Herns 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 72 hours after 1 □ Never Married 2 Narried 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas: Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☒ No þ Specify: Asian Indian 3 Widowed 4 Divorcad Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Heal Elamantary/Sacondary (0-12) College (1-4or 5+) Professor 5+ State University 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumame) Be Doddanna Narsimmanna Sakamma (Not Available) 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prasad Doddanna/Son 6131 Morning Calm Way, Columbia, Maryland 21045 20b. Placa of Disposition (Name of cametary, crematory or other placa) June 28, 1998 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signatura of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin M01126 Avenue, Bethesda, Maryland 20814-3501 plications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) **Examiner** (or as a consequence of): Physician/Medical Examiner VET FTASTASBI The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Entar Underlying Cause (Diseasa or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) P.O. Box 68760, Due to (or as a consequence of): been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably # ☐ Unknown Records, Be Completed by 24b. Were autopsy findings evalleble prior to completion of cause of death? 24a. Was an autopsy performed? GRIGHSINN page 2 1 Yes 2 No this certificate 1 Yes 12 No Division of Vital Hospital or Attending Physician: director, 25. Was casa referred to medical axaminer? 26. Placa of Death (Check only one) 1 ☐ Yes 20 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4☑ Nursing Home 5☐ Residence 8 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Natural 5 Pending Investigation death. 1 Yes 2 No To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the filled in 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to the cause(s) Medical and mannar stated. 29b. Signature end title of certifier 29d. Data signed (Month, Day, Year) 29c. License number woll 10 30. Name and eddress of person who completed causa of death (Itam 23a) (Type, Print) RNEEM AKHANI 1220 ARK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Silia Davidson-Rondall Registrar

DHMH 16 Rev 6/95

Dun



Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Be Certification: To

Robey, Virginia

Robey, Virginia

23b. Did tobacco use contribute to the cause of death?

Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical				26. Place of Death	(Check only one)
examiner?	Hospital: 1 Inpatient 3	ER/Outpatient	3□ DOA	Other: 4 Nursing Hom	e 5 Residence 6 Other (Specify,
27. Manner of Deeth 1 Neturel 5 Pending Investigation	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury et 2: Work? 1 Yes 2 No	8d. Describe how injury occurred

3 Suicide 6 Could not be determined 4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Roufe Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a, Certifier

erman

29c. License number 500

29d. Date signed (Month, Day, Year) 7/2/90

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

John Heffernan, M.D. 215 Bloomingdale Avenue Federalsburg, Maryland 21632

State Registrar

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31. Date filed (Month, Day, Year) JUL 0 2 1998



To the Hospital within 24 hours a To the Funeral Completely filled

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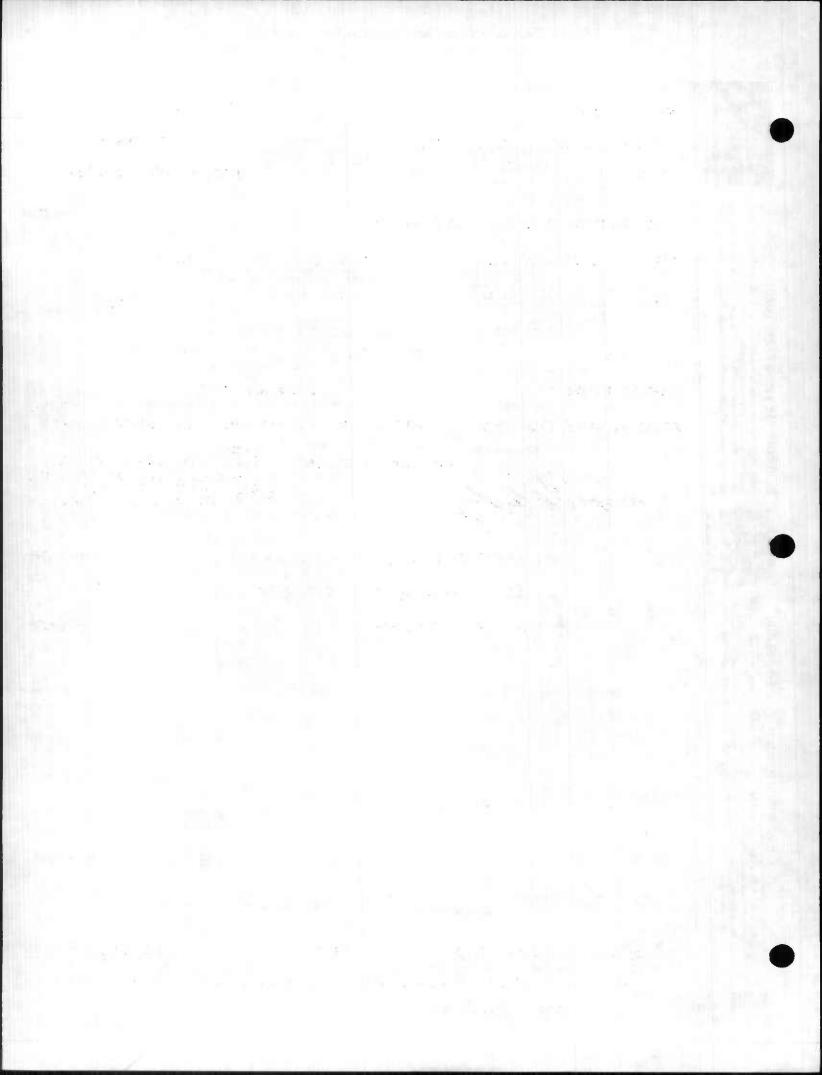
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month Day **Physician** JUNE 26th, 1998 11:30 A.M. ALMA MAY ROWE /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street end number) Examiner MONTGOMERY COUNTY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthpleca (Stete or Foreign **Funeral** 1 M 2XX Months Days Houra 80 Yrs. JULY 10, 1917 VIRGINIA **Director** 577-09-0910 Usual Residence of Dacedent the Menyland r 28a-f ahow i notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita 1 ☐ Yea XX No Directo MARYLAND MONTGOMERY GAITHERSBURG 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours after death with in and Mental bytjene.

7 is marked other than "netural; or items 23a or items 24 or items 25 or U · S · A · Funeral 8619 HAWKINS CREAMERY ROAD 20882 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, atc. 1 ☐ Yes 2000 If Yes, Give Yaer or Detea: 1 Naver Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0020 1 Yes 200No Specify: by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) OWN HOME 12th HOME MAKER 18. Mother's Name (First, Middle, Meiden Sumame, 17. Father's Name (First, Middle, Last) Be 2 FLORA ANN ROBEY CLARENCE EDWARD CHEEK Department of Health and M. Important: If item 27 is many injury or other pince. 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 20882 19a. Informent's Name/Relationship (Type, Print) 8619 HAWKINS CREAMERY ROAD GAITHERSBURG MARYLAND DENISE R. GIBBS (DAUGHTER) 20b. Plece of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 20e. Melhod of Disposition Dete JULY 1, XM Burial 2 Cramation 3 Removel from State 1998 4 ☐ Donetion 5 ☐ Other (Specify) BRENTWOOD MARYLAND FORT LINCOLN CEMETERY 21. Signature of Funeral Service Attenges 22. Name end Address of FacilityHINES-RINALDI FUNERAL HOME, 11800 NEW HAMPSHIRE AVENUE SILVER SPRING MARYLAND 20904-2891 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on #parting death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, Approximate Intervet Between Onset and Deeth Physician Immediate Cause (Finel disaese or condition resulting in death) /Medical MINUTES . CARDIO - RESPIRATORY ARREST **Examiner** Due to (or as a consequence of): Examiner TWO MONTH ISCHEMIC HEART DISEASE certificate be executed physician and s the burial-trans Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. ONE WEEK · ACUTE LEUKEMIA Physician/Medical Due to (or as a consequence of) 95 esn P.O. 23b. Did tobacco use contribute to the cause of death? Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. detached 1 Yes 2 No 3 Probably 4 Unknown à Division of Vital Records, 8 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy Completed page 2 has 1 Yes 21 No 2/19/10 certificate 1 ☐ Yes or Attending Physician: Be 25. Was cese referred to medicei axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospital: 1 Inpatient 1 Yes 2 No P 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: After 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No r death. investigation 2 Accident 24 hours efter deat Funeral Director: 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of triury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and menner as stated edical completely 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the To the 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. Licanse number gayadar D43358 JUNE 26, MD address of person who completed cause of deeth (Item 23e) (Type, Print) Grace E. Sagayadan, M.D. 849-CQUINCE ORCHARD BLVD, GAITHERSBURG 20878 MD 31. Date filed (Month, Day, Year)
JUN 2 9 1998 39 Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

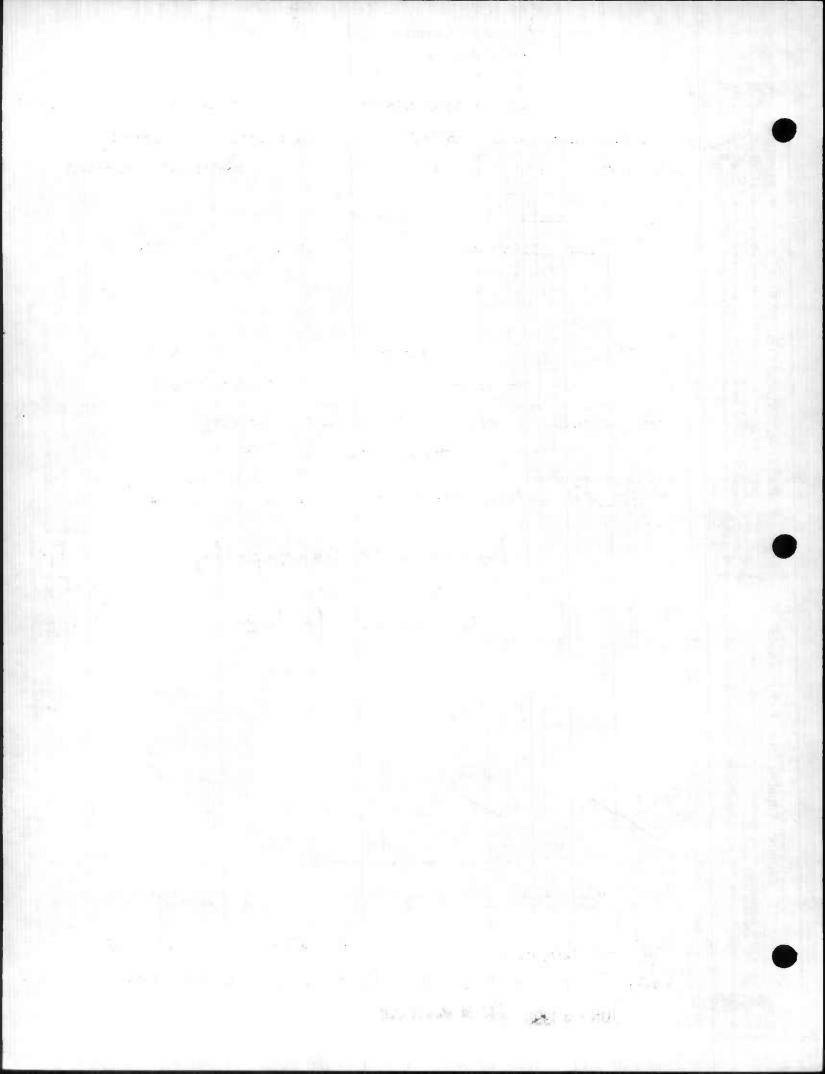
					C	ertificate	e of	Death		Reg. No.	0 6	1639
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Funeral Director		214-32-4776	M 2□ F		'5 Yrs	Months	Days	Hours Min.		1923	Mary	pleca (State or Foreign ntay) Land
pue *		Usual Rasidance of Decedant 10a. Stete 10b. County		10c. Cit	y, Town or	Location					1	10d. Inside City Limits
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the the	Director	10e. Street and Number				10f. Zip				10g. Citizen of 1	What Cour	ntry?
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death	Funeral	11. Marital Stetus	12. Was Decede		,S. 1	3. Wes Deced	lant of I	lispanic Origin? (S	pecify Yes or No			can Indian,
Ind 21215-0020 be filed within 72 hours after death with the Meryland ital hygiene. d other than "natural", or items 23s or 23-4 show event, the Medical Exament must be included.	by Fu	1 ☐ Nevar Married 2 ☐ Marriad 3 ☑ Widowed 4 ☐ Divorced	Armed Force 1 Yas 2 If Yas, Giva Yaar or Date	No No		1 ☐ Yas		Specify:	o Hican, atc.)		ck, Whita, y: Whi	
2 ho	ted	15. Decedent's E				cedant's Usua		pation during most of wo	dring	16b. Kind of B	usiness/In	dustry
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arylan should be nd Mental marked o	၉			aver	100 14	-W A 11-00-	(0)					0.4.1
C 0 0 0 0		19a. Informant's Name/Ralationship Carol Sue Dodso		or				Rd., Tai			787	Coda)
1 and 1 and Health em 27 other tr		20a. Method of Disposition	ni, adagne	20b. F	Pleca of Di	sposition (Nan	na of	1	Data	20c. Location		own, Stala
altimore, mit. Pages 1 at partment of Hea portant: If Nem: y Injury or othe		1 Surial 2 Crametion 3 4 Donation 5 Othar (Speci		C	ematary, c	UCC Cen	thar ple	ce)	06/29	Taneyto		
Baltim permit. Pag Department Important: any injury once.		21. Signature of Funeral Servica Lice	Riles	_ M005	534	22. Nama an		ss of Facility Sl Sltimore S	kiles Fu			21787
		23a Pany Enter tha disaasa, or com or heart failure. List only	plications that cau	sed the deat	h. Do not							Approximate fnterval Between
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/Medical - Examiner		Immediate Cause (Final disaasa or condition	. 15	chen	u, c	Car	-di	bhyop	outhy			4- Jyvs
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68760 ficate be e physician is the buni		causa. Entar Undarlying Ceuse (Diseasa or Injury thet initiated evants	c	M-	re	nal		as lus	۲`			1-275
687	edical	rasulting in daath) Last		Due to (o	rasa con	sequance of):	•					
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IS, P.O. BOX 65 es that the death certific igned by the attending p be deteched for use as	Physician	Part II. Other significant conditions	contributing to daat	h but not ras	ulting in th	e underlving c	ausa qi	ven in Part I.	23b. Dld	tobacco usa co	entribute t	o the cause of death?
	hys		Cat	70		, ,			10	Yes 2□ No	3 □ Pro	babty 4 Unknown
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of Vital Rec systetion: The law his certificate hes b i director, pege 2 s	Be C	25. Wes casa refarred to medical						26. Place of Da	ath (Check only	one)		
ysicia ysicia is cer direc	ToB	examiner?	Hospitel:	patient 2	ER/Outpa	tient 3 DC	A Ot	har: 4 Nursing h	Homa 5□ Rasi	dence 6 □Ott	har (Speci	(y)
		27. Mannar of Death 1 □ Naturai 5 □ Pending	28a. Data of (Month,	Injury Day Year)	28b. Tim Injui	a of 2	8c. Inju	ry et rk?	28d. Dascribe	how injury occur	rred	
VISION Of VITA Attending Physician: or death. ector: After this certific by the funeral director,	atlo	2 ☐ Accident investigation	n			М		Yas 2 No				
- +25-	Certification:	3 Suicida 6 Could not be detarmined	28a. Placa o	f Injury - At he , atc. (Spacif	oma, farm,	, straat, factory	, office		28f. Location (City or To	Straat and Num wn, Stete)	ber or Run	al Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edicai (29a. Certifier (Check only one)	nysicien: To the be miner: On the bas and menne	is of axemina	wiedga, de tion end/o	eath occurred r Investigation	at tha ti	ma, data and place opinion, daath occu	e, and dua to tha urred at the tima,	causa(s) and m data and place,	annar as s and dua t	stated. to the causa(s)
To the within To the compl	Me	29b. Signeture and titla of certifier				290	. Licen	se number		29d. Data signa	ad (Month,	Day, Year)
->-0		1 , 1 / 1	- L				13	STO 1-		6/26	154	,

State Registrar

31. Data filed (Month, Day, Year) JUN 2 9 1998

30. Name and address of person who completed cause of deeth (Item 23e) (Typa, Print) STED, S - (170 LAT N M), Y12, Malalm 32. Registrar's Signetura

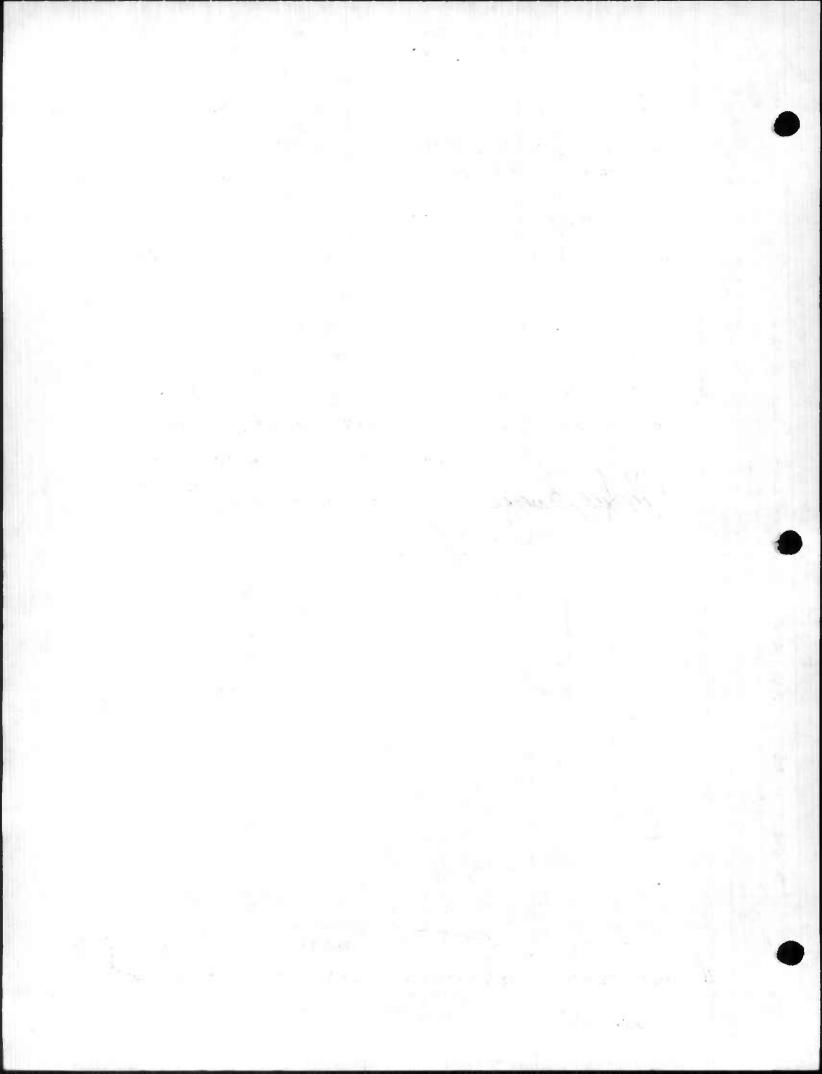
a. Westminster MJ 21157



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death **Physician** ELSTE ELIZABETH SMITH JUNE 26 1998 12:25 AM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Berlin_Nursing_and_Rehabilitation_Center_ ocle! Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Berlin Worcester If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Birthpleca (Stata or Foreign Country) **Funeral** Months Days 1□M 2XF 220-26-7882 88 Director 10/30/09 MD Usuel Residence of Dacedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Worcester 1 ☐ Yes 2 No Director MD Berlin 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ŏ 238 10723 Sinepuxent RD 21811 USA Funeral Rema 12. Was Dacedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarlcan Indien, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Itam 27 is merked other than "natural", or ther any injury or other traumatic event. Black, White, atc. 1 ☐ Yes 2 🕱 No If Yes, Give Yaar or Detes: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 XNo þ Specify: 3X Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highast grada complated) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 9 Homemaker Home 17. Fether's Nema (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumema) Be 10 Charles Rodney Annie Henman 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) 11530 Quillin Way Berlin, MD William D. Smith/ Son 21811 20e. Method of Disposition 20b. Plece of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, State 1 Burlel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) **Evergreen Cemetery** 6/29/98 Berlin, MD 22. Name and Addrass of Fecility
Burbage Funeral Home nevare 108 William St. Berlin, MD 21811 t ceused the daath. Do not enter the moda of dying, such es cerdiac or respiretory errest, each line. Approximete interval Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Due to (or es e consequenca of) Examiner e dostas 90 Hospital or Attending Physician: The law requires that the death cartificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last and Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco uss contributs to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown maturia by 24b. Wara eutopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? has 2 No 1 ☐ Yes 2 No certificate 1 Yes Be 25. Was cese referred to medicel exeminer? 26. Place of Deeth (Check only ona) Hospitel: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA Other: Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident Director: in by the 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the ceuse(s) end menner steted. 29e. Certifier Medical 29b. Signature and title of cent 29d. Data signed (Month, Day, Year) 29c. License number H43617 nd address of person (Item 23e) (Type, Print) 10514 RACETRACK RD. BERLIN MD 21811 410-641-8585 SCOTT SWEENEY MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State wydson-Randell Registrar JUN 2 6 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	Certificate of Death	Reg. No.	21641
Dhualalan	1. Decedent's Neme (First, Middle, Last)		2. Dete of Deeth	3. Time of Death
Physician /Medical	IDELLA Taylor S	mith	UNE 18 19	
Examiner	4a Facility Neme (If not institution, give street end rumber)	4b. City, Town, or Loca	ation of Deeth 4c. County of	Deeth
	PENINSULA REGIONAL MEDICAL CENTE			OMICO
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last b) 1 M 2 X	Yrs. Hunder 1 Yeer If Under 24 Hrs. Months Days Hours Min.	(Month, Dey, Year)	Birthplece (State or Foreig Country)
the Maryland 28e-f show notified at	10a. Stete 10b. County 10c. City, Tox	wn or Location		10d. Inside City Limit
filed within 72 hours after death with the Maryland thygiene. ther than "natural", or items 23a or 28a-f show but, the Medical Examinet must be notified at a Completed by Funeral Director	100. Street and Number 99.32 Hotel Rd	10f. Zip Code 218/3	10g. Citizen of Wh	et Country? States
keme keme	11. Marital Statua 12. Wes Decedent Ever in U,S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Cuben, Mexican, Puerto Ri	ify Yes or No-	American Indian, White, etc.
ours after rat, or lu Enemin	1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes:	1 Yes 2 XNo Specify:	Specify:	BK
"natural", adeal Ex-	15. Decedent's Education 166 (Specify only highest grade completed)	Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Bush	ness/Industry
filed within 72 how they then "natural ent, the Wederal e Completed	Elementery/Secondery (0-12) College (1-4or 5+)	Domestic	House	WORK
be filed other avent,	17. Fether's Neme (First, Middle, Last)	18. Mother's Name ((First, Middle, Meiden Sumeme)	
12 should be filed within h and Mental Hygiene. 7 is marked other than treumatic avent, the M	JAMES Taylor 19e. Informent's Neme/Reietlonship (Type, Print) 19	b. Mailing Address (Street and Number or Rural	Route Number, City or Town, St	lete, Zip Code)
5 = 2 ± 5	Sgrah Over daughter) 9	930 HOTEL DI	Bishopville, ,	nd 21817
- 포 등 등	20e. Method of Disposition 20b. Place	of Disposition (Neme of ery, cremetory or other place)	Date 20c. Location - Ci	ity or Town, Stete
0 - 5	1 Buriel 2 □ Cremation 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)	MT ZION BART, CH. 6	27/00 Da : 100	- \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
pemit. Pag Department Important: I any Injury o	21. Signeture of Funerel Service Licensee		so / Ware	UB.
permit. Departimport. any Inj	No. 7 C 1. To a Ton	22. Name and Address of Facility FUN	Home Ass	11
	23a Part 1 Enter the disease or complications that caused the death. Do	22/7/ Wharter	Rd Aecom	Approximate
Med S	23e. Pert1. Enter the disease, or complications that caused the death. Do shock, or heart feilure. List only one cause on each line.	Thot enter the mode of dying, such as cardiac or	respiretory arrest,	Intervel Between Onset end Deeth
Physician / /Medical	Immediate Ceuse (Final	ALEMIA		4 Hour
Examiner	resulting In deeth)			4 40010
ē	A CUTE RE	a consequence of):		4 DAYS
be executed sician and buriel-transit	b	ENAL FAILURE		1 721112
execute and and and and and and and and and and	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	e consequence of):		
sicial burn		consequence of the		
entificate be ling physicia ie as the bu	resulting in deeth) Lest	consequence of):		
death cer ed for use siclan/A	Pert II. Other eignificant conditions contributing to death but not resulting	in the underlying cause given in Pert I.	23b. Did tobacco uee contr	ribute to the cause of dea
as that the de igned by the a be detached i	CONGESTIVE HEART		1 □ Yee 2 □ No 3	Probably 4 Junkn
been s should	DISSEMINATED INTRA	VASCULAR COAGULATION	24e. Wes en eutopsy performed?	24b. Were eutopsy finding eveileble prior to completion of cause of deeth?
The page			1 ☐ Yes 2 ☑ No	1 Yes 2 No
entification, setor,	25. Wes case referred to medical exeminer?	26. Plece of Deeth	(Check only one)	
hysic lidire To		Outpetient 3 DOA Other: 4 Nursing Hom	e 5 ☐ Residence 6 ☐ Other	(Specify)
	27. Menner of Deeth 1 Neturel 5 Pending (Month, Dey Yeer) 2 Accident investigation 28a. Dete of Injury (Month, Dey Yeer)	Time of Injury et Work? M 28c. Injury et Work? 1 □ Yes 2 □ No	Bd. Describe how Injury occurred	d
no Hospital or Attending P no 24 hours after death. The Funeral Director: After t pletaly filled in by the funers edical Certification:	3 Sulcide 8 Could not be determined 28e. Plece of Injury - At home, building, etc. (Specify)	ferm, street, factory, office	Bf. Location (Street and Number City or Town, State)	or Rural Route Number,
To the Hospital or Atte within 24 hours after de To the Funeral Direct completaly filled in by it Medical Certific	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge on the basis of examinetion early end manner stated.	je, death occurred et the time, dete end plece, ar ind/or investigation, in my opinion, death occurred	id due to the ceuse(s) and mann d et the time, date end plece, an	ner as stated. Id due to the cause(s)
othe ithin othe omple	29b. Signeture end title of certifier	29c. License number		(Month, Day, Year)
F 3 F 8	Yal this, M		2 JUNE	
		(Type, Print) LA REGIONAL MEDIC	AL CENTER.	MD 2180
State Registrar	31. Dete filed (Month, Dey, Year) JUN 2 9 1998 32. Registrer's Signature	Mandalle		

110 44 5 50 160 Later the stranger to better the improve 98-3614-039 SHOCKLEY 98-136

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Certificat	te of	Death		Reg. No.	C.	. 1076
MARYLAND RTE#13 Social Security Number 6. Sex 7. Age (in yrs. last birthdey) 1 Under 1 Year 1		2. Dete of De	th Dey Year 3.1		3. Time of Deeth					
• •	JERRY ODEL SHOO	CKLEY, SR.					Month JUNE	24	1998	1425 P
						4b. City, Town, or I	1	- 1		1123 1
aminer		,							RSET	
		Say 7 An	a (la um lant hist	hdout if Unde		Princess If Under 24 Hrs.	Anne			lane (Ctate or Familia
				Months		Hours Min.	(Month, Da	y, Year)	9. Birth	place (State or Foreign
tor			31	13.			11/08	/66		MD
			100 City Tour	or Leasting						Od Incide City I Imite
1 .	Too. State		Toc. City, Town	OI LOCATION						10d. Inside City Limits
5	VA Accoma	ack	Atlant	tic						1 ☐ Yas 2 ☐ No
9	10e. Street and Number			10f, Zij	p Code			10g. Citizen of	Whet Cour	ntry?
0	10445 Smith Land				223	03		USA		
era			Evar in U.S.	13. Was Dece			pecify Yes or No		ce - Americ	can Indian,
5		Armed Forces?		If Yes, spe	cify Cub	an, Mexican, Puerl	o Rican, atc.)	Ble	ck, White,	
>		If Yes, Give	NO	1□ Yes	2 X No	Specify:		Specif	y: Bla	ack
D	3 Widowad 4 Divorced	Yaar or Datas:								
ete	15. Decedent's (Specify only highest of	Education rede completed)	16e.	Decedent's Usu (Give kind of wo	al Occup ork dona	pation during most of wor	king	16b. Kind of B	usiness/In	dustry
d			0+)							
0	12		T	ruck Dr	iver			Poultr	У	
e	17. Fathar's Nama (First, Middle, Las	st)				18. Mother's Ner	ne (First, Middle	, Maiden Sumai	na)	
0	Woodrow W. Shoo	ckley, Sr.				Virginia	a L. Dal	.e		
-			19h	Mailing Addres	s (Stree	0		-	. State Zir	Code)
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5		Tambusi from State	cemeter)	, crematory or	othar pla	ice)	Dete	20c. Location	- City or 10	own, 51919
2	4 Donation 5 Other Spen	(y)	Shiloh	Bantis	t Ce	metery	5/27/98	Atlanti	c VA	1
童。	21. Signature of Fungral Baryce Do	ongoo //	DITTE	22 Nama a	nd Addre	ess of Fecility				•
800	Danu ////	how Ih.		COOPE	R &	HUMBLES 1	FUNERAL	CO., IN	IC.	
/	Sermine VIII	aper, W.							1	
	shock, or heart failure. List only	frefications that caused yone cause on each is	the death. Do n	ot enter the mor	de of dy	ing, such as cardial	or respiratory a	mest,		Approximete Interval Between
3		/							- 4	Onset end Death
	Immediate Cause (Final	724-50	WIN 1	AARILE						
		9 164-Q		Control of the second						
ě			man to far an a c	- and an ine rul						
늗		b							-	
Xa	Sequentially list conditions, if any, leading to immediate		Due to (or as a c	onsequence of)						
	Cause (Disease or Injury	0								
Cal	that initiated events		Due to (or as a co	onsequence of):						
Aec	The second secon									
		d								
등	Death Other slee Wood and Col	and the diameter of the Co.	of east part between	Marine Co.		one in Burn	905 814	tobasan una	and allow the T	o the same of do it.
Completed by Physician	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying	cause gr	ven in Part I.	100000000000000000000000000000000000000	11		o the cause of death
2							10	Yes 209No	3 Pro	bebly 4 Unknow
b									1	
8								an autopsy omed?	BV	ere autopsy findings silable prior to
ë							, passe		00	empletion of cause death?
Ë							4	1		
8							10	Yes 2 No	- 4	yes 2□No
Be	25. Was case referred to medical examiner?					26. Place of Dec	ath (Check only	one)		
2	1)© Yes 2□ No	Hospital: 1 Inpate	ent 2DER/Out	patient 3 D	OA CO	4☐ Nursing h	lome 5 Rasi	Idence 6 Dot	her (Specia	(y) ROADWAY
	27. Manner of Death	28a. Date of Inju «Month, Da	ry 28b. T	ime of	28c. Inju Wo	ny at	28d. Describe	how injury occu	rred (A)	1947 Fire
윤	1 ☐Natural 5 ☐ Pending 2 SPAccident investigati	46	60 12	258 M		Yes 2 No				eturned DN
Certification:	3 ☐ Suicide 6 ☐ Could not	be one Disease (1st	ury - At home, fer		ry office	The state of the s				
Ŧ	4 ☐ Homicide determine	building, et	c. (Specify)		y, onice					el Route Number,
d n		2	POSOWD	4			RIBSB	& Rives!	DIM	, somenset u

29a. Certifier (Check only one)

RTBSB & MILLUSS ALME, SOMERSET O 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, end due to the cause(s) and manner es steted.

2 Medical Examinar: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E

JUNE 25, 1998

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

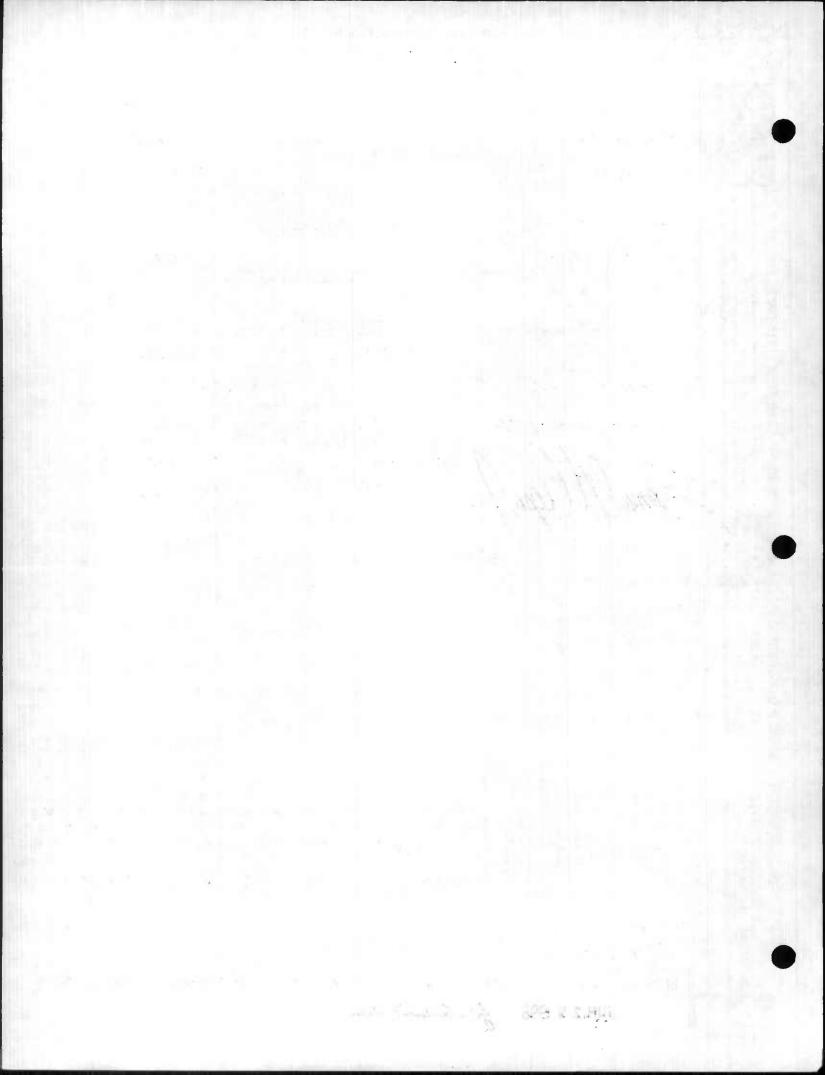
HDRYSPUS Korun pen

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical

32. Registrer's Signeture The Davids



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) Month **Physician** June 25, 1998 3:54 PM Richard Smith /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery H Undar 24 Hrs. 8. Data of Birth (Month, Pay, Yaar) 926 If Undar 1 Yaar 5. Social Security Number 7. Aga (in yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 X M 2□ F Months Days 577-30-2977 71 Yrs. Nebraska Director Usual Rasidance of Dacedan the Maryland 10c. City, Town or Location 10h County 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28a-f show treumstic evant, the Medical Examples must be nothled at 1 Yas 2(XNo Director Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? United States 1801 Metzerott Road 20783 Funeral death 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas: Unknown 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11 Marital Status Black, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any follow yor other theumatic event, the Medical Experiment 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ♥ No Specify: à 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Porter Hotel 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Smith Unavailable (Unavailable) 19b. Mailing Addrass (Streat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) (quardian) 401 Hungerford Drive, 2nd fl., Rockville, MD 20850 Marjorie S. Lappen 20b. Place of Disposition (Nama of cematary, crematory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Chesapeake Crematory 6-26-98 Beltsville, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Rapp Funeral Services, P. A. Brud 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Entar tha disaasa, or complications that causad the daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one cause on each line. **Physician** /Medicai Immediata Causa (Final diseasa or condition rasulting in death) Examiner Examiner physician end the bunal-transit Sequanfially list conditions, if any, laading to Immadiate cause. Enter Underlying Causa (Diseasa or Injury that Initiated avants resulting In death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua fo (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the a 23b. Did tobacco use contributa to the causa of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Zophrenia Old Stroke with à 24b. Wara autopsy findings svallabla prior to completion of causa of daath? 24a. Was an autopsy parformed? Completed right hemiparesis, Urinary Incontinence hes Ola Alcohol Abuse 1 Yas 2 No 1 Yas 2 No Division of Vital after death.

Director: After this certifications Be 25. Was casa rafarrad to medical axaminer? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) funeral 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 28a. Data of Injury (Month, Day Year) 5 Panding invastigation 1 X Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 - Homicide 24 hours a Funeral D 10 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. edicai 29a. Cartifier To the I 29b. Signatura and title of fertifie 29c. Licansa number 29d. Data signed (Month, Day, Year)

State Registrar

31. Dafa filad (Month, Day, Year)

JUN 2 9 1998

Su Hogistrace Signature Pondalle

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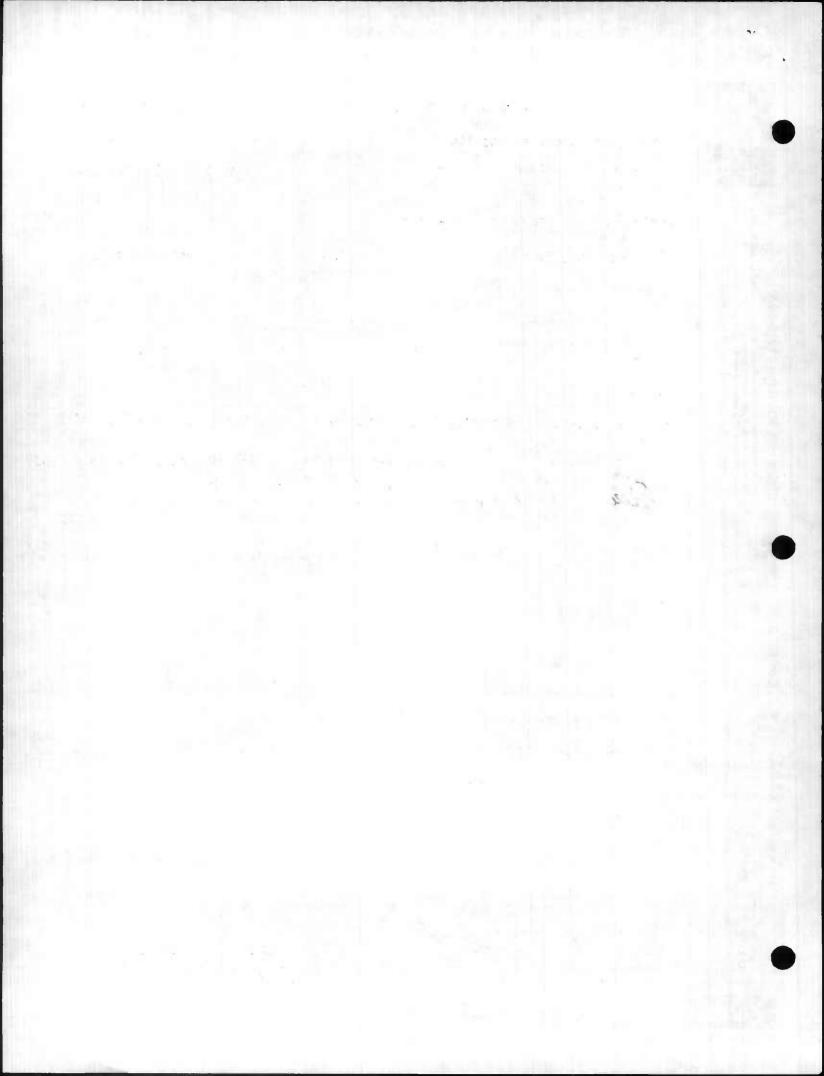
30. Nama and addrass of parson who complated course of daash (Nem 23a) (Type, Print) 7500 Greenway Center Drive, #430 8.17.1

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Greenbelt,

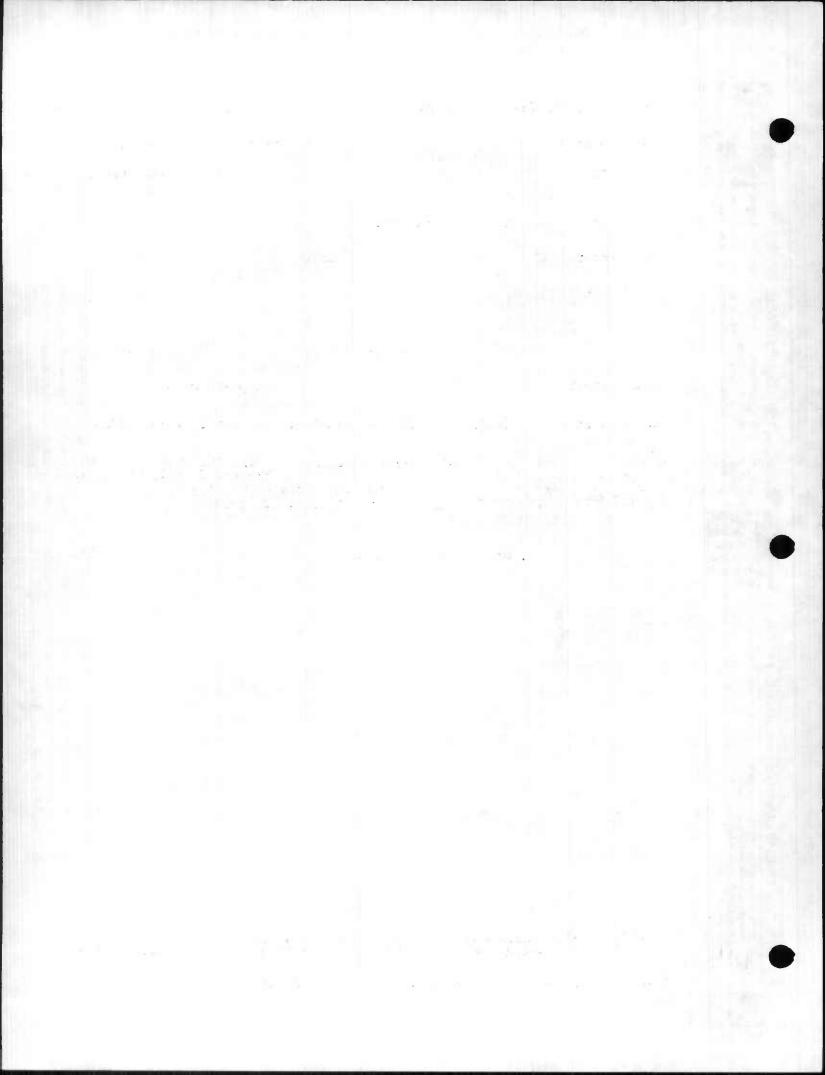
June 26, 1998



State of Maryland / Department of Health and Mental Hygiene 98 21644

					Cel	rtificate	UUI	Dealli			Reg.	. No.			
Maria Lada a	1. Decedent's Ne	me (First, Middle, La	ist)							2. Dete of D	eeth	Dev	Year	3. Tim	e oi Deeth
hysician /Medical	SAMUEL	SALVA	DORE	SH	LAVATT						25,			5	:05PM
kaminer	4e Fecility Neme	(If not Institution, given	e street end num	ber)				4b. City, To	wn, or Lo	cation of Dec	eth	4c. County	of Death		
		arbell Rov				1 Willadas	1 V-11	Colu				Howa			
al or	5. Sociel Security 578-22- Usuel Residence	-8185	Sex 7 1 ☑ M 2 ☐ F	73 Age (In yrs.	lest birthdey) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Dete of E (Month, L April	Day, Ye	ear) 1925	Coun	(rv)	te or Foreign
rector	10e. Stete	10b. County		10c. Ci	ty, Town or Lo	ocation							1	0d. Inside	e City Limits
to	MD	Prince G	Genroes	н	yattsvi	1110								101	res 2 No No
Director	10e. Streei end N		002800		, 4000	10f. Zip	Code				10g.	. Citizen of V	Vhei Coun	try?	
	2201 An	nherst Roa	ıd				20	783				USA	A		
Funeral	11. Maritel Status 1 □ Never Ma	arried 20 Married	12. Wes Deced Armed Ford 1 17 Yes 2 If Yes, Give	es?		Wes Deced li Yes, spec			gin? (Spe 1, Puerto	cify Yes or N Rican, etc.)	lo-		e - Americ k, White,	etc.	
d by	3 Widowed	4 Divorced	Year or Det	es: WWI	I	100 1	200110	ороспу.				Specify		Whit	e
Completed	(Spi	 Decedent's E- ecify only highest great 	ducation ade com <i>pleted)</i>		16e. Dece	dent's Usue kind of wor	el Occup rk done	oation du <i>ring</i> m <i>os</i> s d)	t of worki	ng	161	b. Kind of Bu	isiness/inc	dustry	
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o Be	Frank S								Jose	phine	DeF	ao			
F	19e. Informent's I	Neme/Reletionship (Type, Print)		19b. Maili	ng Address	(Street					City or Town,	State, Zip	Code)	
		R. Shavat		e)						ttsvil			20783		
	20e. Method of Di		(1122		Pleca of Dispo cemetery, cres				11,50	Date	-	c. Location -			9
		2 Cremelion 3 5 Other (Special		tate	Vetera				16	/30/09	Ch	ol tomb		MD	
		Fuperal Service Lice		TID	vetera 2	2. Name en	nd Addre	ess of Fecilit	Fra	ncis J	. C	eltenh Collins	s Fun	eral	
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			plications that car	used the data				ing,			arrest	t.		Approxi	mete
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al er ja	Immediate Ceuse disease or condit resulting in death	e (Finel tion)		Due to (c	h. Do not ent	Cance	er				arrest	ł,		Onset a	Between nd Deeth
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State Registrar 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture JUN 2 9 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert William Swain, Sr. June 27, 1998 1:15 PM /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery ff Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys 1♥ M 2□ F Yre 278-07-1165 80 Director July 8, 1917 Ohio Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 238 6010 Walton Road 20817 United States Funeral Hems 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritaf Stetus hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Nevar Merried 2 X Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 ☒ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Pegas 1 and 2 should be filed within 7 nant of Haalth and Mental Hygiene. nnt: If item 27 is marked other than "r National Institutes Elementary/Secondery (0-12) College (1-4or 5+) of Health 5+ Radiation Physicist 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Harry L. Swain 2 Carol Redman 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pegas 1 and 2 s Department of Haalth an important: if item 27 is a any injury or other trau Martha W. Swain/Wife 6010 Walton Road, Bethesda, Maryland 20b. Place of Disposition (Neme of cametery, cremetory or other place) July 2, 1998 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burlel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00846 LAND Bru 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) a Small Cell Carcinoma of Lung 3 Months **Examiner** Due to (or as e consequence of): Physician/Medical Examiner The law requires that the death certificate be executed physician end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): USB P.O. Pert II. Other signiffcant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Cushings Syndrome, Parkinson's Disease signed t þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en autopsy performed? Ulcerative Colitis page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No after death.

Director: After this certifice Be 25. Was case referred to medical exeminer? 26. Pleca of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funaral 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Dev Year) 1 XNaturai 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 Homicide To the Funeral D

Division of Vital Records, • Funeral

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To the To the To the I

Lee R. Pennington, M.D., 31. Date filed (Month, Day, Year) JUN 2 9 1998

5602 Shields Drive, Bethesda, Maryland 20817 32 Registrar's Signature Julia Davidson-Randella

enning ton, and

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

dical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s)

29d. Date signed (Month, Day, Year)

June 28, 1998

29c. License number

D21115

Registrar **DHMH 16 Rev 6/95**

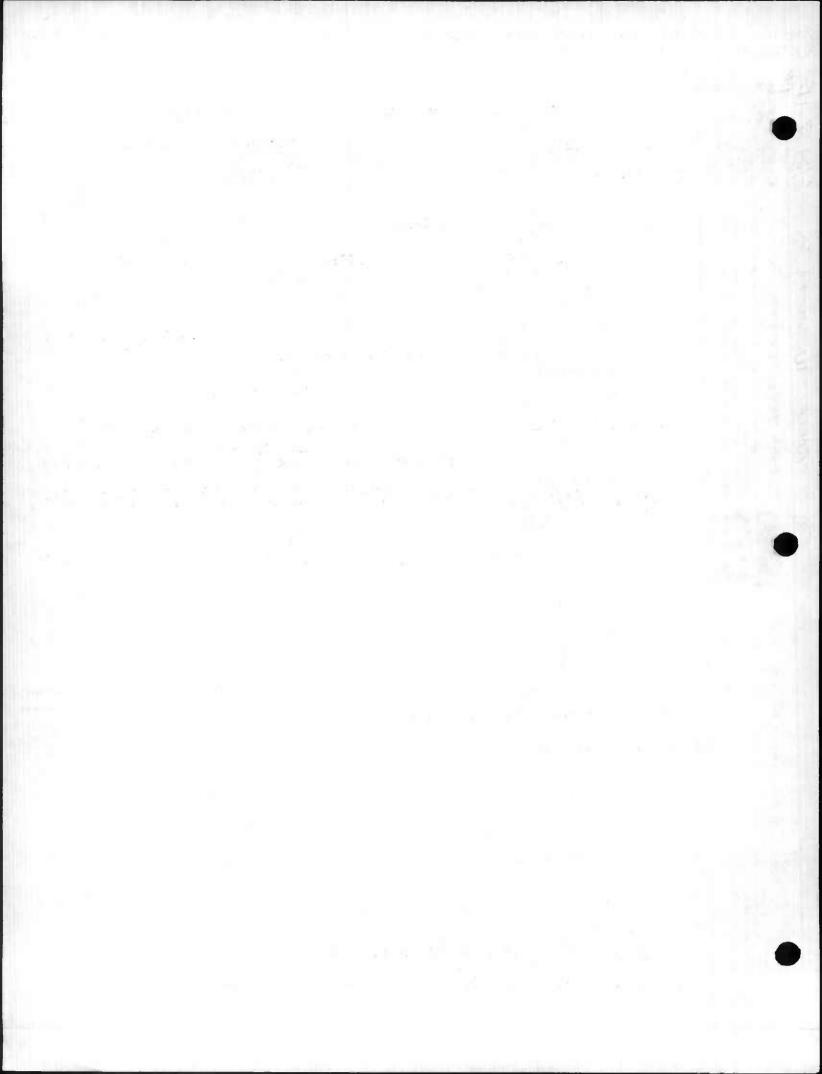
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29a. Certifier

(Check only one)

29b. Signature and title

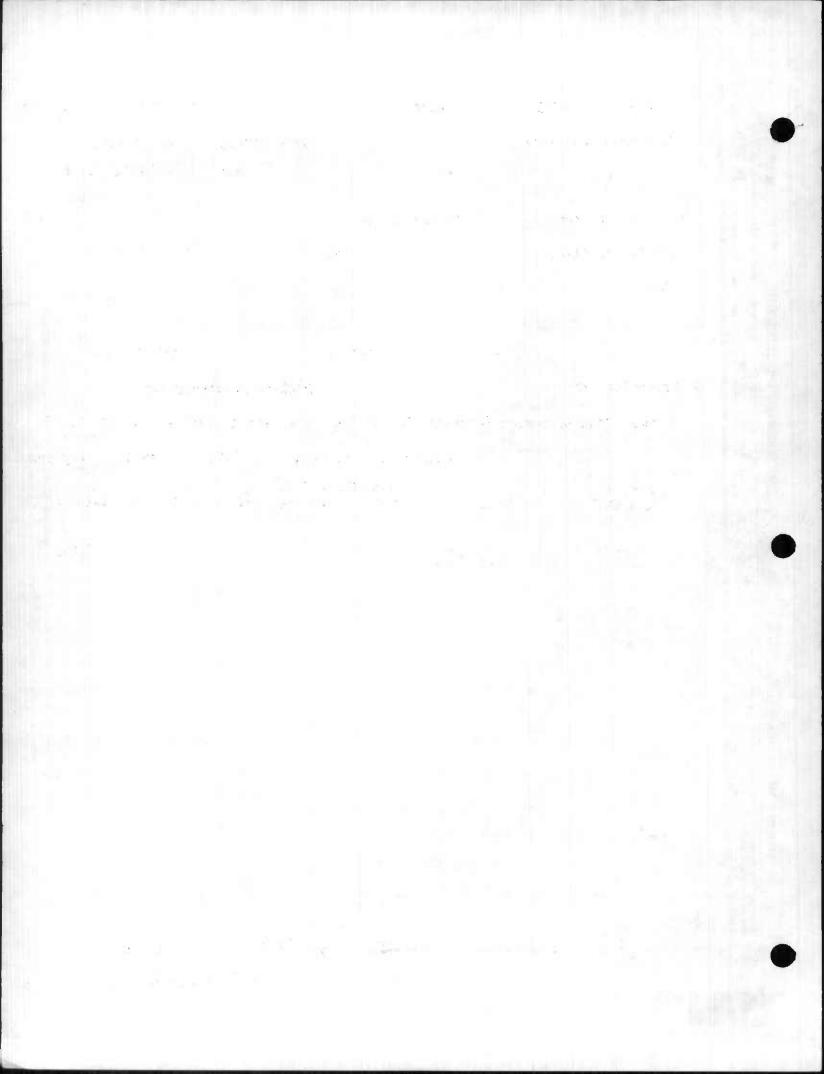


State of Maryland / Department of Health and Mental Hygiene Q 2 1 5 1 6

Physician Month				C	ertificate of	Death		Reg. No.	41	040	
JOSEPH SANDLER JUNE 27, 1998 SANDLER SANDLER SANDLER SCH, Tom, or Location of Death Sc. Course	Dharatatan	1. Decedent's Nama (First, Middle, Las	st)							. Tima of Death	
Social Security Number Security Properties		JOSEPH		SAN	NDLER					8:30 PM	
Source Security Numbers		4a Facility Nama (If not institution, give	a street and number)			4b. City, Town, or	Location of Dea	th 4c. County	of Death		
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SAM SANDLER 19. Informant's Name/Faletionship (Type, Print) 190. Melting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 190. Informant's Name/Faletionship (Type, Print) 190. Melting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 190. Informant's Name/Faletionship (Type, Print) 190. Melting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 190. Mended of Disposition 190. Informant's Name/Faletionship (Type, Print) 190. Melting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 190. Mended of Disposition 190. Mended of Disposition 190. Mended of Disposition 190. Mended of Disposition 190. Part I Enter The States of Sepocity 21. Signature of Service Information 22. Name and Address of Facility 23. Sequentially list conditions, Consecution of Service Information 22. Name and Address of Facility 23. Sequentially list conditions, Consecution of Service Information 24. Developed of the Print Red States of Service Information 25. Name and Address of Facility 26. Sequentially list conditions, Consecution of Service Information 26. Due to (or as a consequence of): 27. Sequentially list conditions, Consecution of Service Information Information 28. Sequentially list conditions, Consecution Information Information Information 28. Sequentially list conditions, Consecution Information	r than tre Man			lif	a. DO NOT usa ratire	ed)		INSURA	NCE		
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ROBERTA WEINER/DAUGHTER 20e. Method of Disposition (Secretary Command) 21. Signature of Transposition of Secretary Command of Command Comman	DE E		Stata, Zip Co	de)							
Supply S	127 r	ROBERTA WEINER/DA	LAND	20850							
21. Sonature of the search Service Ser	5 - 5			b. Place of Di cematary, o	sposition (Nama of cramatory or other pla	ace)	Data	20c. Location -	City or Town,	Stata	
193 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 29a. Part I. Enter The Seases or contiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. 29a. Part I. Enter The Seases or contiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. 29a. Part I. Enter The Seases or contiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. 29a. Part I. Enter The Seases or contiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. 29a. Part I. Enter The Seases or contiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. 29a. Part II. Other significant conditions to cause (Disease or Injury that inhelied events resulting in death) Last 29b. Did tebacco use contribute to the cause (Disease or Injury that inhelied events resulting in death) Last 29c. Was case referred to medical apprinar? 29c. Was an autopsy performed? 29c. Localion (Street and Number or Rural Route Cause College on death investigation of modern shallow). 29c. Licensa number 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day, Year) 29d. Date signed (Monn), Day			r) R	RICHMON	D BETH-EL	CEMETERY	6/24/98	RICHMO	ND, VI	RGINIA	
Part Enter the Theseas or contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Appropriate the property of the pr	Depart Import any in ance	21. Signature of Famousi Service Licen	505		EDWARD SAG	GEL FUNER				T	
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Due to (or as a consequence of): Cause (Diseases or influry that initiated events resulting in death) Last	Medical xaminer	Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									
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4,0	Holy Cros			Age (In yrs.	last birthday)		r 1 Year	Silver S	rs. 8. Date of B	irth .	Montgo	. Birthple	ce (State or Foreign
	577-52-51	.61	1□M 2 X 1F	67	Yrs.	Months	Deys	Hours Mi	rs. 8. Date of 8 (Month, D	1, Year	1930	Hary	V)
_	Jsuel Residence of Oa. Stete	10b. County		10c. Ci	ty, Town or Lo	cation						100	d. fnside City Limits
1	Maryland	Montgom	erv	Sil	ver Spi	rina							1 ☐ Yes 2 ☐ No
_	0e. Street end Num		J		op.	10f. Zip	Code			10g. C	itizen of Wh	at Country	y?
(2700 Barke	er Stree	t			2	0910			Uni	ited S	tate	S
	Maritel Status V		12. Wes Decede Armed Force 1 \(\text{Yes} \) 2[nt Ever in U	I,S. 13. \	Was Dece f Yes, spe	dent of H	ispenic Origin? en, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Bleck,	American White, et	
	Never Marrie		1 ☐ Yes 2[If Yes, Give Yeer or Dete			I □ Yes	2 No	Specify:			Specify:	Whi	te
		15. Decedent's E	ducetion		16e. Deced	lent's Usu	el Occup	etion		16b.	Kind of Busi		
	(Special Special y only highest gi	rede completed) College (1-4)	or 5+)	(Give	kind of wo DO NOT u	se retired	during most of w d)	vorking					
			5+			aut	hor				elf em		ed
	7. Father's Neme (t)						ieme (First, Middle		n Sumeme)		
-	Freder ICk		(Type Print)		19h Mailie	na Address	s (Stroot		en Kell		or Town S	tete. Zin C	Code)
		•	derick (c	ousin		_							22309
54	Oe. Method of Disp	osition		20b. I	Plece of Dispo	sition (Ne	me of		Dete		Location - C		
	1 Donetion		□Removal from Ste ify)		esapeal				7-2-98	Bel	ltsvil	le,	Maryland
	21. Signeture of Fun	eral Service Lice	ensee		22 D -	Neme er	nd Addre	ss of Fecility	icos D	۸			
	1 (a	ola	Del		9:	app r 33 Gi	st A	venue.	ices, P. Silver S	n. brir	ng. Ma	rvla	nd 20910
	23a. Pert1. Enter the shock, or heer	disease, or confailure. List only	nplicetions thet ceus y one ceuse on eecl	sed the deal	th. Do not ent	er the mod	de of dyir	ig, such es card	iac or respiretory	errest,		í	Approximate interval Between
	Immediete Ceuse (F	inel											Onset and Deeth
	disease or condition resulting in death)		· 56	208	2								12
				Due to (or es e consec	juence of)	•					1	
,	Sequentielly list con	ditions,	b	Due to (or es e conseq	uence of):	:						
1	Sequentielly list con if eny, leading to im- ceuse. Enter Under Ceuse (Diseese or i	mediete lying niury	6										
1	thet initieted events resulting in deeth) L		0.	Due to (d	or es e conseq	uence of):							
		U	d									-	
	Part II Other staniffs	ant conditions	contributing to death	hut not res	ruiting la the u	ndedvina	causa ah	en in Part I	23h Di	1 tobacc	o use cont	ribute to 1	the cause of death?
•	Pert II. Other signific	on conditions	contributing to death	, pat 110f 162	ronning in the U	adding (oouse giv	OTHER DICK				Probe	/
4													
									24e. We	s an eut formed?	opsy	avei	re autopsy findings leble prior to apletion of cause
-		: #										of de	eeth?
	VC 1014	44									2 NO	10	Yes 2 No
	25. Wes case referre exeminer? 1 \(\text{Yes} \) 2 \(\text{T} \)		Hospitel:	ation: O	ER/Outpatier	nt 3 D	OA Oth	or:	Deeth (Check only) Home 5 Re		6 DOther	(Specific)
1	27. Manner of Deeth		28e, Date of I	njury	28b. Time of		28c. Injui Woi		28d. Describe				
	1 Naturel 2 Accident	5 Pending Investigation		Dey Yeer)	Injury	М		Yes 2□No					
	3 ☐ Suicide 4 ☐ Homlcide	6 Could not l	286. Piece of	Injury - At h	ome, farm, str	eet, factor	y, office		28f. Location City or T	(Street own, Ste	and Number	or Rurel	Route Number,
_													
1			hysician: To the be miner: On the besi end menner	of exemine									
L	29b. Signeture end t	itle of certifier	eno menner	SIGIGU.		29	c. Licens	e number		29d. D	Date signed	(Month, D	Day, Year)
à	1					_ '	1	1150	7				
	456		A CONTRACTOR OF THE PARTY OF TH		200	20 1) 4	1-1-	/	T	1000	9 1	996
	30. Name end eddre	ss of person who	o gompleted cause of	of deeth (Ite	m 23e) (Type,	Print)	29	Seldi		Ju	ne 2	9,1	20902



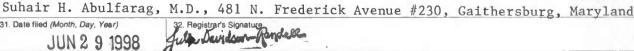
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** homas tarnet telen June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) ADVENTIST HOSPITAL ROCKVILLE

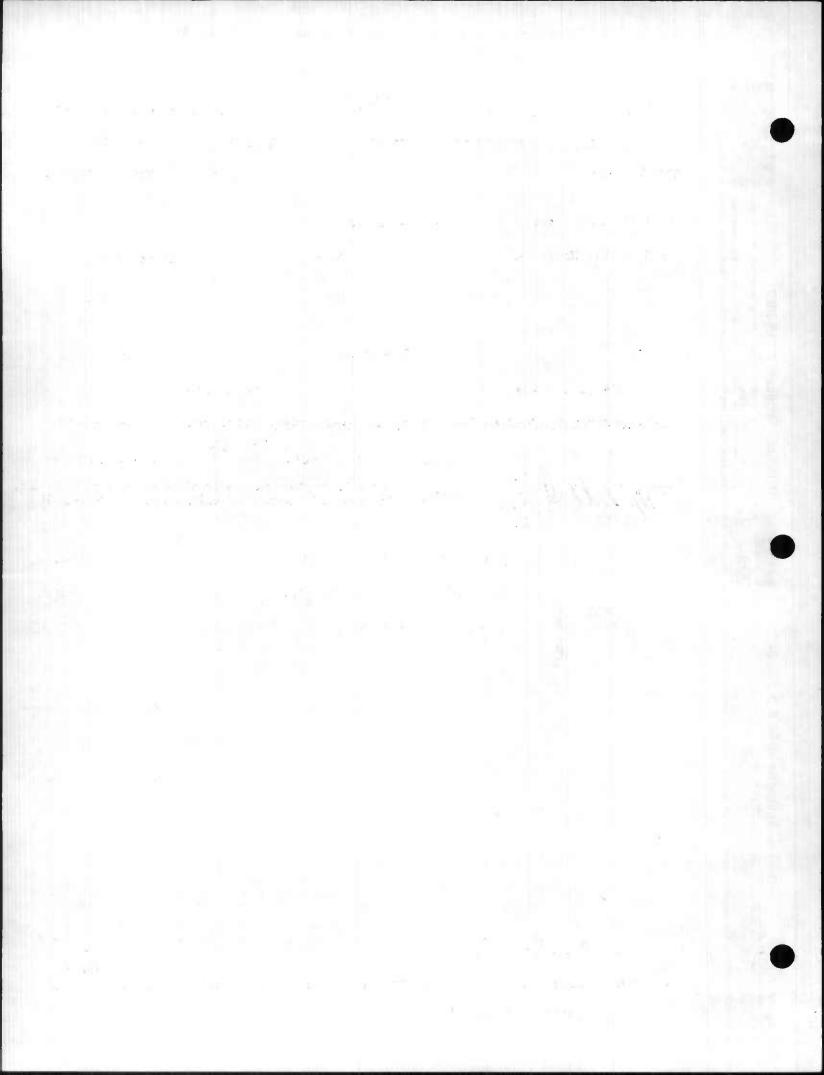
ADVENTIST HOSPITAL ROCKVILLE

The standard number of the stan Examiner SHADY GROVE MONTGOMERY 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□ M 200 F Yrs. 155-36-7307 91 **Director** December 14, 1906 Illinois Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 19310 Club House Road 20886 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Charles Vowles Lydia Rainey 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) () 1845 19a. Informant's Name/Relationship (Type, Print) 9 Royal Crest Drive, North Andover, Massachusetts W. Arthur Bingham/Son in Law 20b. Place of Disposition (Neme of cametery, crematory or other place) June 29, Date 1998 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc M00846 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 MA that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical pneu mou ia Examiner Examiner and transit Tha law requires that the daeth certificata be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last physician a s the buriel-1 Spinal Division of Vital Records, P.O. Box 68760, Sherrosis Physician/Medical Due to (or as a consequence of) 98 980 Po signed by the a 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? cartificata hes b 1 Yes 2 No. 1 ☐ Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Day Year) funeral 27. Menner of Death 28d. Describe how Injury occurred Certification: 28h Time of 28c. Injury at Work? Attar 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No death. 2 Accident eftar death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hou. the Funeral Direction of filled in by 4 Homicide Hospital 29a. Certifier 🏠 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. edicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred et the time, date and placa, end due to the ceuse(s) and manner stated. To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number June 26, 1998 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20879

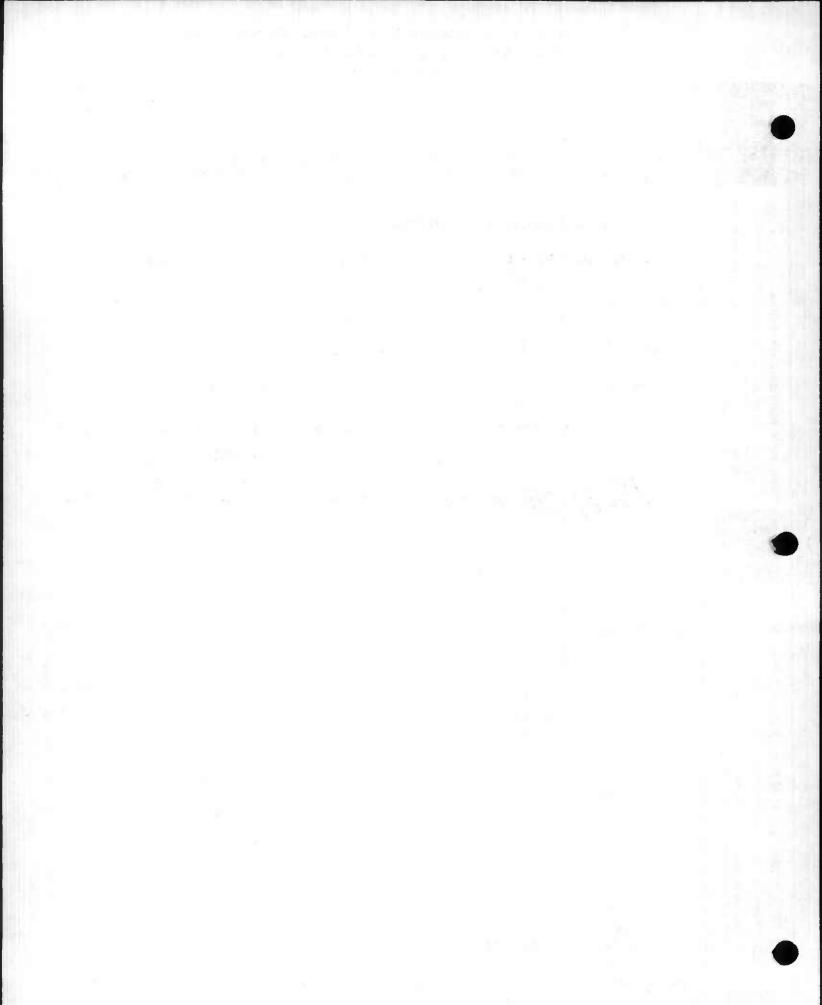
State Registrar

31. Date filed (Month, Day, Year) JUN 2 9 1998





Physic /Med	ian	1. Decedent's Neme (First, Middle, La.		111				2. Dete of De	-	Yeer .	Time of Death
	icai	Zoelma S. 4e. Fecility Name (If not Institution, giv.	Thomas				4b. City, Town, or I	June 2		1	0:00am
Exami	ner	630 Sheridan Stre	ACT AND ACT OF THE PARTY.				Hyattsvi			e Georg	0
Funeral	Г	5. Sociel Security Number 6. S		(In yrs. last b		der 1 Year	If Under 24 Hrs.				(State or Foreign
Director		530-07-9969	□M 2√2 F	85	Yrs. Month	s Deys	Hours Min.	8. Dete of Birl (Month, Da June /	1913	Country)	arolina
2	1	Usuel Residence of Decedent 10a. Stete 10b. County		10c City Toy	vn or Location					1011	
(aho	ŏ	5.0									Inside City Limits I □ Yes 2∑ No
288	Director	MD Prince (10a. Street end Number	seorge's	Нуасс	sville	Zip Code			10g. Citizen of		
23.0		630 Sheridan S	treet #110)	2	0783			USA	•	
and a	Funeral	11. Maritel Status	12. Wes Decedent E Armed Forces?		13. Was De	cedent of H	lispanic Origin? (S an, Mexicen, Puert	pecify Yes or No	14. Rac	ce - American in	ndien,
a priority of the control with the control of the c	by	1 ☐ Never Merried 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Yeer or Detes:	lo		2 💢 No	Specify:	o r noam, oto.,	Specif		Κ
natur	Completed	15. Decedent's Ed (Specify only highest gre	lucation	166	Decedent's U	suel Occup	etion during most of wor	kina	16b. Kind of B	usiness/Industr	у
9.0	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT	use retire	d)	All Ig			
her th		12			Home	maker			Own Ho		
od off	Be	17. Fether's Neme (First, Middle, Last) John Turner					18. Mother's Nen	Jacobs	Maiden Sumen	ne)	
marked o	1º	19e. Informent's Neme/Reletionship (1	Type Print)	19	h Meiling Addre	es (Stroot	end Number or Ru		r City or Tourn	State Zin Con	(a)
alth er a 27 is er trau			ughter)								
1 2 8		20e. Method of Disposition	J	20b. Place (of Disposition (A	leme of	Street #	Dete Dete	20c. Location	City or Town,	Stete
ant: If its		1X Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify			Lincoln	ourior pro-		7/2/98	Brentwo	od. MD	
Department of Important: If I say Injury or once.		21. Signature of Fymeral Service Licen	500		22. Name	end Addre	ss of Fecility Po	ope Fune			
TO E S S		Alex Posse	TI MO	0883	11315	Lock	wood Dr.	Silver	Spring,	MD 209	04
600		23e. Pert1. Enter the disease, or comp shock, or heert feilure. List only			not enter the m	ode of dylr	ng, such es cardiac	or respiretory er	rest,	App	proximete ervel Between
hysician										One	set end Death
/Medicai xaminer		Immediate Cause (Final disease or condition resulting in death)	e Cerc	brol	Infar	ction	1			3,	1 days
	اة ا	Tooming in addity	1	Due to (or es e	consequence o	f):				1	
ansit	Examiner		b	2 - 1 - (*	A) .					
an and ial-tra	Exa	Sequentially list conditions, if eny, leeding to immediate	,	oue to (or es e	consequence o	1):					
		cause. Enter Underlying									
ysicia ne bur	Cal	Cause. Enter Underlying Cause (Disease or Injury thet Initiated events	c	Due to (or es e	consequenca o	f):					
ng physician and as the burial-transit	Medical	Cause (Disease or Injury		Oue to (or es e	consequenca o	f):					
		Cause. Enter Underlying Cause (Disease or Injury thet Initiated events	d	Oue to (or es e	consequenca o	f):	-00				
		Cause. Enter Underlying Cause (Disease or Injury thet Initiated events	d				ren in Pert I.	23b. Did t	obacco use co	ntribute to the	cause of death
	Physician/Me	cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in deeth) Lest	dontributing to death bu				ren in Pert I.		obacco use co	ntribute to the	
	by Physician/Me	cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest Pert II. Other significant conditions or	dontributing to death bu				ven in Pert I.	10	res 2ENo	3 ☐ Probably	y 4 ☐ Unknow
been signed by the ettending should be detached for use a	by Physician/Me	cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest Pert II. Other significant conditions or	dontributing to death bu				ren In Pert I.	1 □ '		3 Probably 24b. Were a evalleb comple	utopsy findings
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fler death. Irector: Afler this certificate hes been signed by the ettending in by the funeral director, page 2 should be detached for use a.	To Be Completed by Physician/Me	cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in deeth) Lest Pert II. Other significant conditions or M. J. H. Pert II. Other significant conditions or 25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending	d	nt 2□ ER/O Year) 28b.	utpetient 3☐ Time of Injury	DOA Oth	26. Plece of Deerer: 4 □ Nursing H	24a. Wes perfo	res 25 No en eutopsymed? res 25 No ence 6 Oth ow Injury occur otreet end Numb	3 Probably 24b. Were a evalleb comple of deett 1 Ye her (Specify)	utopsy findings le prior to tion of ceuse h?
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uffer death. Virector: After this certificate has been signed by the ettending in by the funeral director, page 2 should be detached for use a.	edical Certification: To Be Completed by Physician/Me	Cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Pert II. Other significant conditions of Mild Hs page 25. Wes case referred to medical exeminer? 1 Yes 22 No 27. Menner of Deeth 1 Neturel 5 Pending investigation 3 Suicide 6 Could not be 4 Homicide 1 Could not be determined 29e. Certifier (Check only one) 1 Certifying Phy one) Medical Example	d	t not resulting the 2 ER/O (Year) 28b. Try - At home, from (Specify)	utpetient 3 Time of Injury Merm. street, fect	DOA Oth 28c. Injur Wor 1 ory, office	26. Plece of Deerief: 4 □ Nursing H y et k? Yes 2 □ No me, dete end plece pinlon, deeth occur	24a. Wes perfo	en eutopsymed? es 28 No ne) ence 6 Oth ow Injury occur Street end Numb m, Stete) eseuse(s) end me dete end pleca,	3 Probably 24b. Were a evalleb comple of deelt 1 Ye her (Specify) red ber or Rural Role enner es stated end due to the	utopsy findings le prior to tition of ceuse n? s 2 No ute Number, ceuse(s)
fler death. Irector: Afler this certificate hes been signed by the ettending in by the funeral director, page 2 should be detached for use a.	edical Certification: To Be Completed by Physician/Me	cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in deeth) Lest Pert II. Other significant conditions or Mild Hz per 25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending investigation 3 Suicide 4 Homicide Getermined 29e. Certifier (Check only one) 29b. Signeture epa title of certifier	Hospital: 28e. Dete of Injun (Month, Day) 28e. Plece of Injun building, etc. 28e. To the best of and manner stell About the best of th	t not resulting t 2 ER/O Year) 28b. Ty - At home, fi (Specify) I my knowledgexaminetion ered.	utpetient 3 Time of Injury Merm, street, fect	DOA Oth 28c. Injur Word, office ory, office od et the tiron, in my office.	26. Plece of Dee	24a. Wes perfo	en eutopsymed? Yes 28 No ne) Hence 6 Oth How Injury occur Street end Numb Mr., Stete) Deuse(s) end me June 24 June 24	24b. Were a evalleb comple of deet 1 Tye There (Specify) Tred Deer or Rural Routenance end due to the end (Month, Dey,	utopsy findings le prior to tion of ceuse h? s 2 No ute Number, ceuse(s)



			Certifica	ate of De	eath	Re	eg. No.	bo	
1. Decedent's Neme (First, Middle, La	ist)					2. Dete of Deet Month	h Day	Year	3. Time of Deeth
MY	Q.		TRAN			JUNE	25	1998	4:00AM
4a Facility Neme (If not institution, give	111)		4b.	City, Town, or L	ocation of Deeth	4c. Count	y of Deeth	
2012 LONGMEAD			u If I lad	ler 1 Year	SILVER f Under 24 Hrs.	SPRING		TGOME	
586-18-0466	Sex 7. Ag	ge (In yrs. last bi	Yrs. Months		Hours Min.	8. Dete of Birth (Month, Day, JULY 14	Year)	Coun	lace (State or Foreign try) TNAM
Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Tow	vn or Location					1	0d. Inside City Limits
MARYLAND MONTGO	MEDV		CTIVE	D ODDI	NO				1 ☐ Yes 2 No
10e. Street end Number	HEKI			R SPRI	NG	1	Og. Citizen of	Whet Cour	ntry?
2012 LONGMEAD	12. Was Decedent	Ever in U.S.	13. Wes Dec	20: sedent of Hisp	906 enic Origin? (Sc	pecify Yes or No-	UNITE 14. Re	ce - Americ	
1 Never Merried 2 Merried	Armed Forces?	?	if Yes, sp	pecify Cuban,	Mexican, Puerto	ecity Yes or No- Rican, etc.)	Ble	ck, White,	etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes:		1 Yes	₩No S	Specify:		Specia	y: VI	ETMINESE
15. Decedent's E	ducation	16a	. Decedent's Us	suel Occupetion	on		16b. Kind of E	lusiness/In	dustry
(Specify only highest gri Elementary/Secondery (0-12)	ade completed) College (1-4or	5+)	(Give kind of w life. DO NOT	vork done dur use retired)	ring most of work	ring			
1.2	Comago (1-40)	.,	OWNER	OPERA'	TOR		ELEGAN'	r NAI	L
17. Fether's Neme (First, Middle, Last)			18	8. Mother's Nem	e (First, Middle, M	Maiden Sume	me)	
AN		TRAN				UNKNOWN			
19a. Informent's Neme/Relationship	Type, Print)	191	b. Melling Addre	ess (Street and	d Number or Ru	ral Route Number	; City or Town	, State, Zip	Code)
MY TO	(WI	(FE) 2	012 LONG	GMEAD 1	RD., STI	LVER SPR	TNG. MI	20	0906
20e. Method of Disposition		20b. Place	of Disposition (N	lame of		Dete	20c. Location	- City or To	
			on cramatory or	r other place)	1	50.0	200. 20041011		
1 Burial 2 Tremation 3			ery, crematory or	r other place)	1				
4 ☐ Donetion 15 ☐ Other (Speci	(y)		LINCOLN	creama'					MARYLAND
	(y)		LINCOLN 22. Name	CREMA' end Address	of Fecility	6-30	BRENTWO	00D, 1	
4 Donellon *\$ Other (Special Signature of Funeral Septice Lice	Devels	FORT	LINCOLN 22. Name HINES- HAMPSI	CREMATend Address of RINALI	of Fecility DI FUNER VE. SII	6-30 RAL HOME	BRENTWO	DOD, 1	NEW 904
4 ☐ Donetion 15 ☐ Other (Speci	Devels	FORT	LINCOLN 22. Name HINES- HAMPSI	CREMATend Address of RINALI	of Fecility DI FUNER VE. SII	6-30 RAL HOME	BRENTWO	DOD, 1	NEW OApproximate
4 Donellon 5 Other (Special Signature of Funeral Septice Lice 21. Signature of Funeral Septice Lice 23. Part 1. Enter the disease or conshock, or heert failure. List only	Devels	FORT	LINCOLN 22. Name HINES- HAMPSI	CREMATend Address of RINALI	of Fecility DI FUNER VE. SII	6-30 RAL HOME	BRENTWO	DOD, 1	NEW 904 Approximete
4 Donetion 5 Other (Special Signature of Funeral Septice Lice 21. Signature of Funeral Septice Lice 23. Part 1. Enter the disease or conshock, or heeft failure. List only immediate Ceuse (Final disease or condition	pube pication of at cause one cause on each I	FORT	LINCOLN 22. Name HINES- HAMPSI	CREMA' end Address -RINALI HIRE A' ode of dying,	of Fecility DI FUNER VE. SII	6-30 RAL HOME	BRENTWO	11800 0. 209	NEW OApproximate
4 Donetton 5 Other (Special Signature of Funeral Septice Loss 23s. Part I. Enter the disease, or companion, or heert failure. List only Immediate Ceuse (Final	pube pication of at cause one cause on each I	FORT do the deeth. Do line.	LINCOLN 22. Name HINES- HAMPSI	CREMA' end Address of RINALI HIRE A' code of dying,	of Fecility DI FUNER VE. SII	6-30 RAL HOME	BRENTWO	11800 0. 209	NEW 904 Approximete Intervel Between Onset end Deeth
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4 Donellon 5 Other (Special Signature of Funeral Septice Loss Signature of Funeral Septice Loss San Part I. Enter the disease or conshock, or heert failure. List only Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	pube pication of at cause one cause on each I	FORT d the deeth. Do ine. ATIC LUN Due to (or es e	LINCOLN 22. Name HINES- HAMPSI not enter the management of the ma	CREMA end Address -RINALI HIRE A ode of dying, CR	of Fecility DI FUNER VE. SII	6-30 RAL HOME	BRENTWO	11800 0. 209	NEW 904 Approximete Intervel Between Onset end Deeth
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4 Donellon 5 Other (Special Signature of Funeral Septice Loss Signature of Funeral Septice Loss	b METASTA b contributing to death be the property of the pro	FORT d the deeth. Do line. ATIC LUN Due to (or es e) Due to (or es e) Due to (or es e) but not resulting	LINCOLN 22. Name HINES- HAMPSI not enter the management of consequence of consequence of consequence of the consequence of the consequence of consequence	CREMA CREMA end Address RINALI HIRE A ode of dying, if): g cause given	of Fecility DI FUNEI VE . , SII such es cardiec	23b. Did to XM Y 24e. Wes e performance of the Check only or come XX Residue.	Description of the property of	118000. 209 11 Solution on tribute to 3 Pro 24b. Way average of 10	O NEW 904 Approximate Intervel Between Onset end Deeth 8 MONTHS o the cause of deeth? bebly 4 Unknown fere eutopsy findings reliable prior to deeth? Yes XXNo
4 Donetion 5 Other (Special Signature of Funeral Septice Loss Signature of Funeral Septice Loss Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Pert II. Other eignificant conditions of the cause in the cause of the cause o	b	FORT d the deeth. Do line. ATIC LUN Due to (or es e) Due to (or es e) Due to (or es e) but not resulting	LINCOLN 22. Name HINES- HAMPSI not enter the many GC CANCE consequence of consequence of	CREMA end Address -RINALI HIRE A ode of dying, (R) (f): g cause given 28c. linjury e work?	of Fecility DI FUNEI VE . , SII such es cardiec	23b. Did to XM Y 24e. Wes e perfori	Description of the property of	118000. 209 11 Solution on tribute to 3 Pro 24b. Way average of 10	O NEW 904 Approximate Intervel Between Onset end Deeth 8 MONTHS o the cause of deeth? bebly 4 Unknown fere eutopsy findings reliable prior to deeth? Yes XXNo

29c. License number

D08754

29d. Dete signed (Month, Day, Year)

20770-

JUNE 26th, 1998

To the Hospital or Attending Physician: The law requires that the death certificata be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and complately filled in by the funered director, page 2 should be deteched for use as the burian-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, in Medical Exercise must be noutrad an once.

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

12

State Registrar

29b. Signature

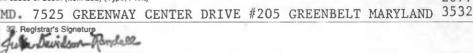
THOMAS

Α.

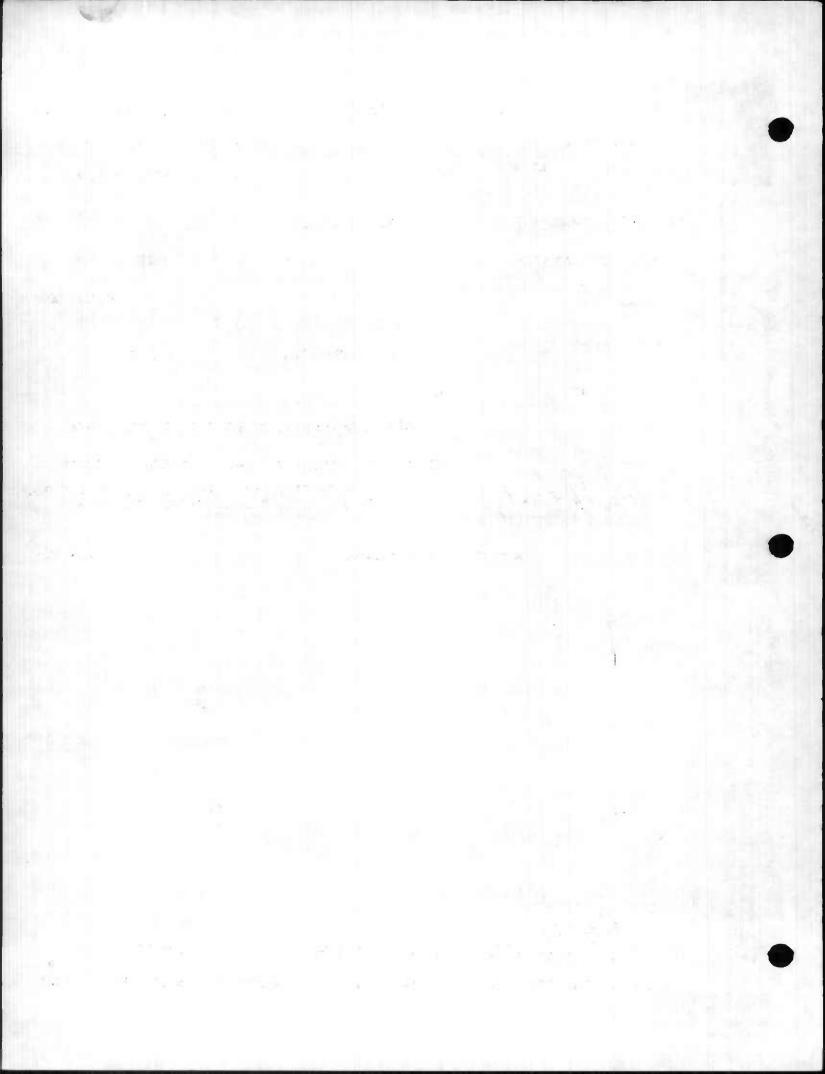
31. Dete filed (Month, Day, Year)

JUN 2 9 1998

BENSINGE



d cause of deeth (Item 23a) (Type, Print)



State Registrar 31. Date filed (Month, Day, Year)

ANN DIXON MD.

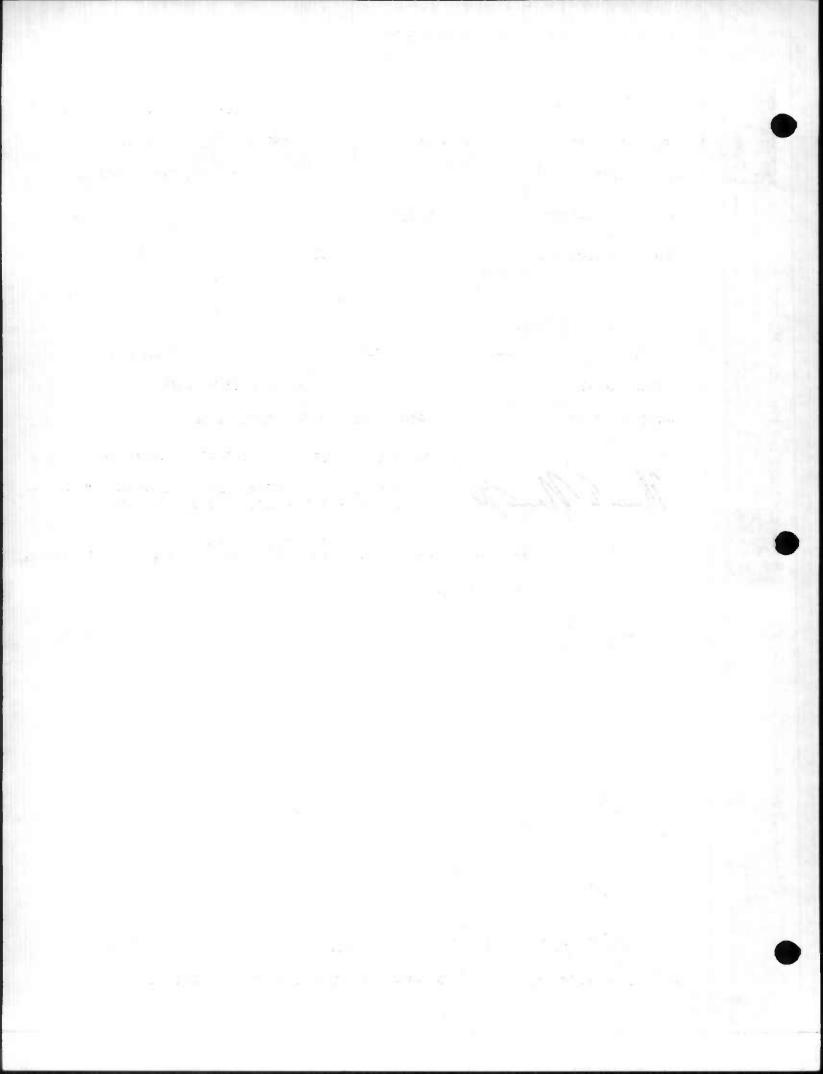
32. Registrar's Signature

JUL 1 4 1998

Julie Davidson Randall

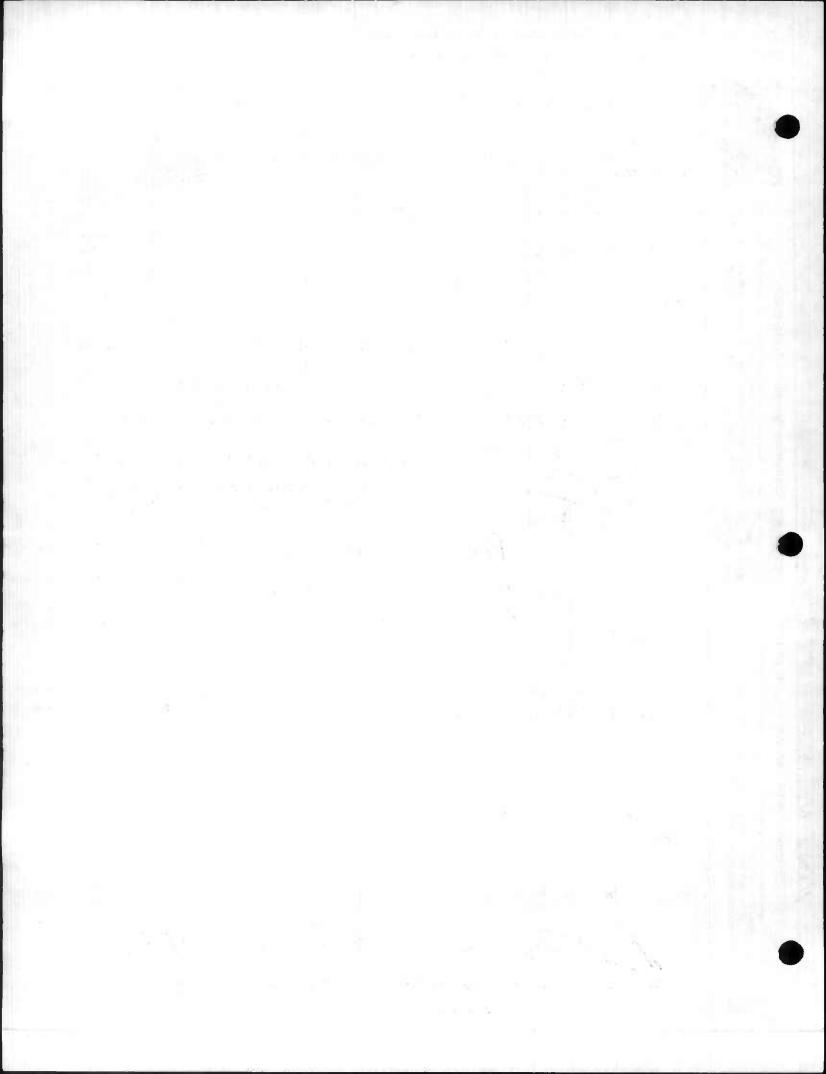
111 Penn St. Baltimore, Md. 21201

					State of	Marylan		artment of F tificate of		Mental Hy	/giene	8 2	21652
	Physici /Medi		1. Decedant's Name	(First, Middle,		X, SR.				2. Date of Da Month JULY	Day	Yaar 198	3. Tima of Death 4:35 PM
	Exami		4e. Fecility Nama (If	not institution,	giva street end nun	nber)			4b. City, Town, or	Location of Dea	th 4c. County	of Death	
			HOSPICE	HOUSE,	586 CYNW	OOD DRI	VE		EASTO	N	TAL	BOT	
	Funeral Director		5. Social Security No. 213-14-21	78	3. Sex 1 🖾 M 2 🗆 F	7. Aga (In yrs. I 82	ast birthday) Yrs.	If Undar 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year) 9,1916	9. Birthp Coun MARY	elace (State or Foreign stry) (LAND
	pue *		Usuel Rasidance of 10a. Stata	10b. County		10c City	, Town or Lo	cation				1	0d. Inside City Limits
	Aeryl	ō	MD	TALBO	ЭТ		EASTON					'	1 X Yas 2 No
	the 1	ect	10e. Street and Num	her				10f. Zip Coda			10g. Citizen of	Affrat Cour	
	with with	ā	410 S. H		2TF			2160	1		USA		Ary r
	leath	era	11. Marital Status	IANDON	12. Was Dace	dant Evar in U.S	S. 13 V			Specify Yas or N		a - Americ	an Indian
020	s 1 and 2 should be filed within 72 hours efter death with the Merylend if Health end Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Expresses must be notified at	by Funeral Director	1 Nevar Marrie	-	Armed For	cas? 2 X No a	1	Yas, specify Cub □ Yas 2 🗓 No	dispanic Origin? (S an, Maxicen, Puar Specify:	to Rican, etc.)	Specify Specify	ck, Whita,	
Maryland 21215-0020	thin 72 ho e. en "netur Medical	Completed	(Speci		Education grada complatad) Collega (1	4or 5+)	16a. Deced (Giva lifa. D	lent's Usuel Occup kind of work dona DO NOT use retire	pation during most of wo d)	rking	18b. Kind of B	usiness/Inc	Justry
21	filed within Hygiene. other than "	Sol	6		-0-		JANI	TOR			UTILI	TIES	
nd	tal H doth	Be	17. Fathar's Nama (ist)						n, Maidan Sumen	ne)	
yla	should be nd Mental I marked of	P	JOSEPH V	VANEX			7		ANTOIN	ETTE MI	TCHELL		
	1 and 2 sho Health end em 27 is me other traum		19a. Informant's Na AGNES G.						and Number or R			Stata, Zip	Code)
Baltimore,			20e. Mathod of Disp 1 N Burlal 2 ☐ 4 ☐ Donation	Cremetion 3	☐Ramoval from S	itale ce	matary, cram	sition (Nama of natory or othar pla LL CEMET		Data 7-6-98	20c, Location -		wn, Stata
Balt	E 0 3			eral Segrice U	gogo /	TI	FE		ELFENBEI				HOME, P.A.
	Physician /Medical Examiner		23e. Pert1. Entar the shock, or haard Immediate Ceusa (f disaase or condition resulting in death)	inal	emplications to t cally ona causa on as	Saco	. Do not ente	ar tha moda of dyli		c or raspiratory a	arrast,		Approximate Interval Batween Onsat and Death Line Constitution of the Constitution of
Box 68760,	death certificete be executed e ettending physician and dior use as the bunel-transit	an/Medical Examiner	Sequantielly list con if any, laading to Im- ceusa. Entar Undar Causa (Disaasa or I that initiated avents rasulting in daath) L		b. +0	Dua to for	s a consequence as a co	deve	1				
		sicis	Part II. Other algnific	ant conditions	contributing to date	ath but not resu	lling In tha un	idarlying causa giv	an in Part I.	23b. Did	1obacco use co	ntribute to	the cause of death?
, P.O	es that the de igned by the be deteched	by Physician/M								1□	Yee 2 No	3□ Prot	bably 4 Unknown
Records,	aw requir ss been s 2 should	Completed t								24a. Wes	s an autopsy ormad?	ava	ara eutopsy findings alleble prior to mpletion of cause death?
œ	0 - 0	E								10	Yas 2 No	10	Yes 2□ No
of Vital	ician: Th certificate rector, par	Bec	25. Wes case rafarra	d to medical					26. Placa of De	ath (Check only	one)		
*	Q 50	To	1 Yas 2 U	60	Hospital: 1 ☐ Ir	patlant 2 E	ER/Outpetient	3□ DOA Oth	ar: 4 🖾 Nursing H	loma 5□ Ras	Idance 6 Oth	er (Specif)	()
	After After fune		27. Menner of Death 1 ☑ Natural 2 ☐ Accident	5 Panding		f Injury), Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. Dascribe	how injury occur	red	
Division	al or Attendes s efter deat if Director: ad in by the	Certification:	3 ☐ Sulcide 4 ☐ Homicida	6 ☐ Could no datermin	28a. Place	of injury - At hor g, atc. (Spacify)	me, ferm, sira	al, factory, office			(Street and Numb wn, Steta)	er or Rura	l Routa Number,
	To the Hospital or Atwithin 24 hours effer of To the Funeral Direct completely filled in by	edicai	29e. Cartifiar (Check only one)	CertifyIng	Physicien: To the taminer: On the bar and mann	sis of axamination	rledga, death on and/or inv	occurred at the tir estigation, in my o	na, data and place pinlon, daath occu	e, and due to the irred at tha tima,	ceuse(s) end me data and place,	enner es st and due lo	eted. tha causa(s)
	To the To the Com	2	29b. Signeture end I	itlerof cartifiar	twoor	(9)		29c. Licens D087			29d. Data signa	d (Month, 1	Day, Year)
			30. Name end eddre WILLIAM						NUE, EAST	ON, MD	21601		
	Sta Registr	-	31. Deta filed (Month	UL - 2		gistrer's Signeti Julia Dav		ndell				\	



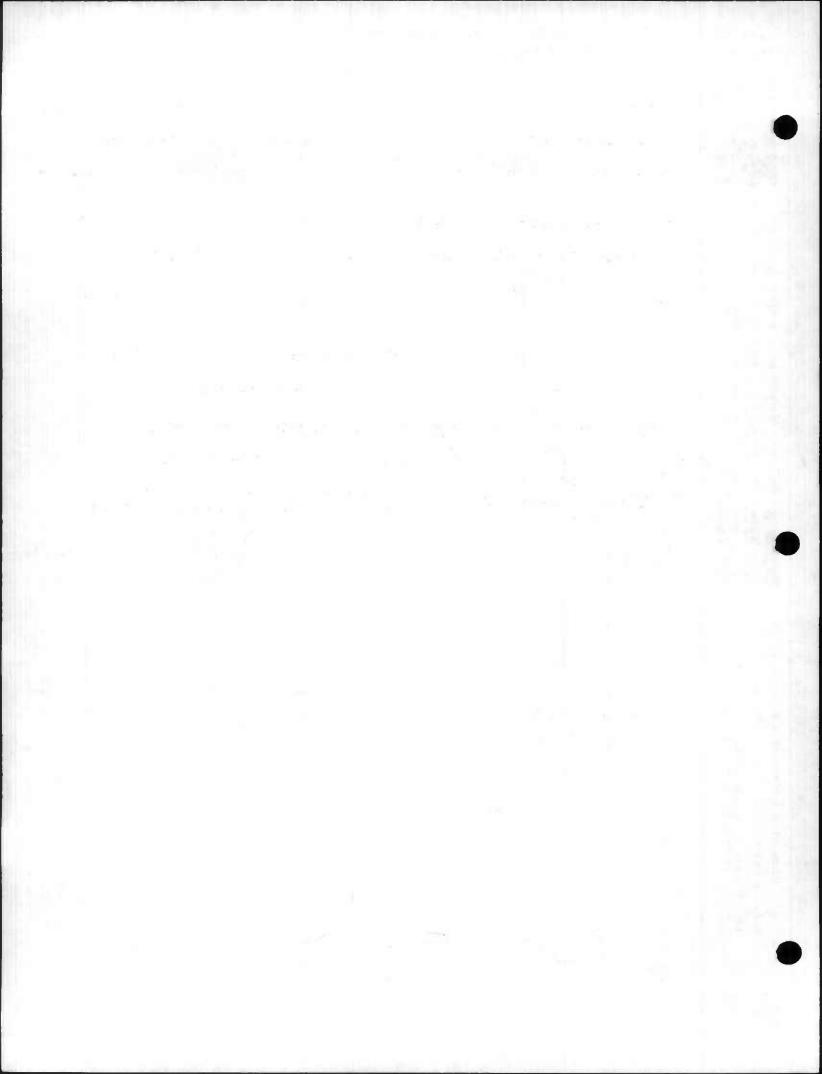
State of Maryland / Department of Health and Mental Hygiene

			- Claic of Marylar		ficate of			Reg. No.	8	21653
	Physic	ian	1. Decedent's Nama (First, Middle, Last) NATHAN J. WEISSMAN				2. Dete of De Month JUNE	28 ^{ay} 199	8 ^{Year}	3. Time of Death 10:38 PM
0	/Medi Examii		4e. Facility Nema (If not Institution, giva streat and number) SUBURBAN HOSPITAL			4b. City, Town, or Lo	cation of Deet	h 4c. County		1
	Funeral Director		5. Social Security Number 113-07-8551 17 M 2 F 79		f Undar 1 Yaer Months Days	If Under 24 Hrs.		th 1/5 Year' 919		place (State or Foreign
		or	Usual Rasidence of Decedant 10a. State 10b. County 10c. Ci MD MONTGOMERY	ty, Town or Locati					1	10d. Inside City Limits 1 ☐ Yas 2 ☐ No
	ith with the Marylan 23a or 28a-f show	al Direct	10e. Street and Number 8508 FARRELL DRIVE		10f. Zip Coda 20815	5		10g. Citizan of VUNITE		ntry?
0020	ours after des rel', or items Examiner in	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U Agned Forces? 1 ☑ Yas 2 □ No WW If Yas, Give Yaar or Datas:	LL	s Decedant of es, specify Cut Yas 2 No	Hispanic Origin? (Spetter, Maxican, Puarto Specify:	ecity Yas or No Rican, atc.)		ce - Americ ck, White, y: WHIT	
21215-0020	I within 72 ho liene. r than "natui m Neoleal	To Be Completed	15. Decedant's Education (Specify only highest greda completed) Elementery/Secondary (0-12) Collage (1-4or 5+)	16a. Decedent (Giva kind lifa. DO INTERNA'	t's Usual Occu d of work done NOT usa ratin TIONAL	pation during most of working dU LOGISITIC	ing S	16b. Kind of B		
Maryland 2	o d at o	To Be Co	17. Fathar's Name (First, Middle, Last) ADOLPH WEISSMAN			18. Mother's Name MOLLY	(First, Middle		na)	
			19e. Informant's Name/Reletionship (Type, Print) LORNA ELGAMIL (DAUGHTER)	3709 1	MESA CO	ot and Number or Rura DURT, ELLI				Code)
Baltimore,	permit. Pagas 1 and Department of Healt Important: if Itam 27 any injury or other i		1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata	Place of Disposition community, cramate NG DAVID	ory or other ple		Dete 30/98	20c. Location -		own, Stata
Ball	Departimord Import any in		21. Signature of Funeral Service Coopuse	DAN		ess of Fecility -GOLDBERG /ILLE PIKE				
Pung	Physician /Medicai Examiner		rasulting in daeth)	EATIC	he mode of dy	ing, such as cardiac o	or respiretory e	rrast,	1	Approximate Interval Batween Onset and Death / WES(T
8.58.10.38 Box 68760,	eath cartificate be executed attanding physicien and for use as the buriel-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiate waste and the second of the cause.	META STA	171/LT, 2	(FRIM PAN	CREATIL	CATEIN	(-٢٠	1 west
28 0.B	that tha death cared by the attandidate of the attandidate detached for usa	sicia	Part ii. Other significant conditione contributing to death but not ras	uiting In tha unda	ntying causa gi	ivan in Part i.	23b. Did	tobacco use co	ntribute to	the cause of death?
S, P.	requires that the death car been signed by the attandir hould be detached for usa	by Phy	COMMANY ANTENY DISSAIR				10	Yes 205 No	3 Prol	bably 4 ☐ Unknown
Ellman	Z S	Completed					24e. Was perfo	an autopsy ormed?	av:	ara autopsy findings aliabla prior to mplation of cause daath?
$\sqrt{\Sigma_{\ell,\ell,\ell}}$			25. Was casa refarred to medical					Yas 2□No	10	☐ Yas 2☐ No
3 >	Physician: this cartific ral director,	To Be	axaminar?	ER/Outpatient	3□ DOA Ot	26. Place of Death		ona) dence 8 □Oth	er /Specifi	(v)
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	r Health frem 27 other tr		Gloria We		lbert	Daughte	f 6 Bee	chvue C	t, Silve					
Baltimore,	or and or		20a. Method of Dispo 1 ☐ Burial 2 ☐	Cremation 25	Removal from	State /		etory or other pie		Dete	20c. Location			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth BILLY THOMAS WILLIAMS JR. JUNE 28, 1998 12:40 AM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Clinical National Institutes of Health, Center Bethesda Montgomery 8. Date of Birth (Month, Day, Year) June 17, 1963 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Min. 1 M 2□ F Months Days Hours Florida Yrs 35 231-84-6135 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 Yas 2 No Washington, DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 2611 Adams Mill Road 20009 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elementery/Secondary (0-12) Collega (1-4or 5+) Agent Real Estate 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Thomas Williams Bettie Lou Roop Billy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) Bettie R. Williams (mother) 544 Brightwaters Drive, White Stone, VA 22578 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Ramoval from State Chesapeake Crematory 6-29-98 Beltsville, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility
Rapp Funeral Services, P. A. 21. Signature of Funaral Service Licensee 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest,

Approx Approximate Interval Between Onsat and Death Immediate Ceuse (Final disease or condition resulting in death) Lymphoma HODGKIN Due to (or as a consequence of): ACQUIRED IMMUNE DEFICIENCY SYNOROME Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. 3 Probably 4 Unknown 1 Yss 2 No 24b. Were eutopsy findings available prior to 24e. Was en autopsy performed? completion of cause of death? 2 No Yes 2□ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA

Physician /Medical **Examiner**

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The law requires that the death certificate be axecuted

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: if fam 27 is marked other than 27 is marked other than 2006.

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Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

25.	Wes case referred to medical axeminer?
	1 Yes 2 No
27.	Manner of Death

1 Natural
2 Accident

3 Sulcida

4 | Homicide

5 Pending investigation 6 Could not be determined 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred

28f. Locetion (Streat and Number or Rural Routa Number, City or Town, Stete)

edicai (Check only one)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signad (Month, Day, Year) 29c. Licanse number

29b. Signatura and titla of certifier

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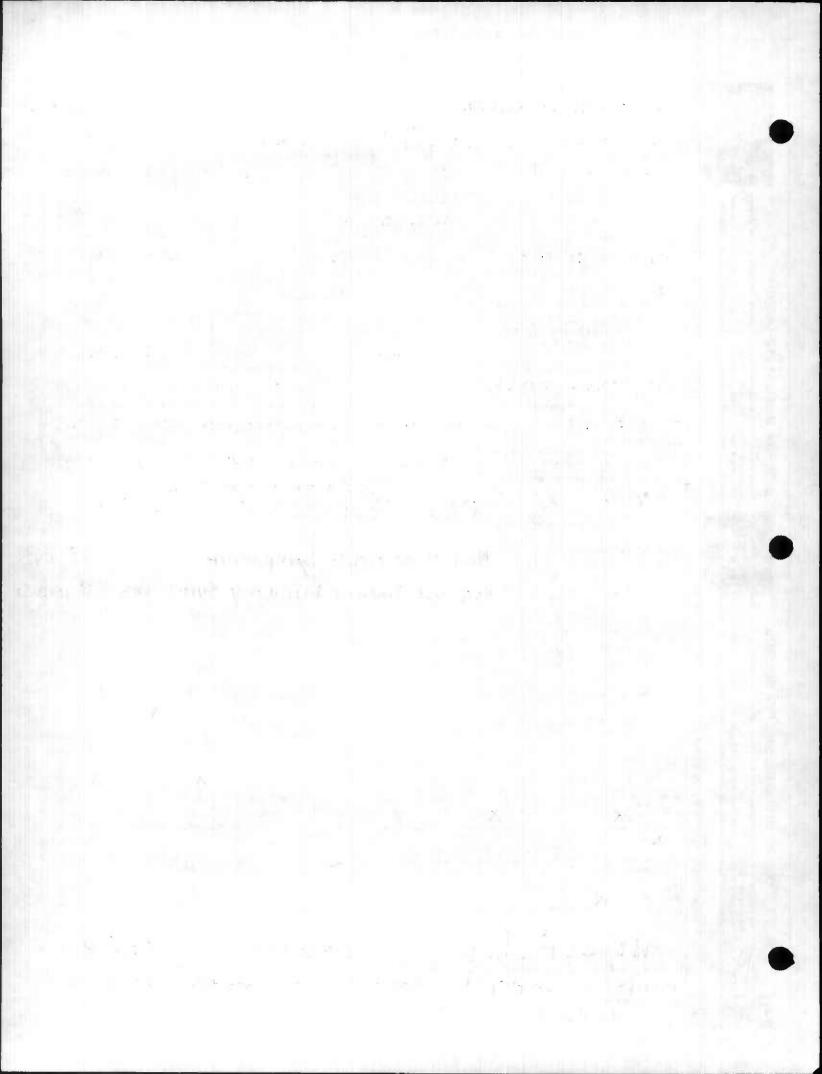
and eddless of person who completed cause of eth (Item 23e) (Type, Print)

. BISHO PHILIPPE C 31. Date filed (Month, Dey, Year)

9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892

State Registra

2. Registrere Signature Randelle JUN 2 9 1998



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Burton D. Willis July 1998 0020 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Hours Min. 8. Dete of Birth (Month, Day, Year) If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) XIM 20 F Months Deys 221-03-7075 81 Lincoln, DE Usuel Residenca of Decedent 10c. City. Town or Location 10d. Inside City Limits 10e. Stete 10b. County 1 ☐ Yes ŽÜNo Milford Kent DE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19963 US 189 Jenkins Pond Rd 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Dates: 42-46 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Livestock Dealer Self-Employed 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Jonathan S. Willis Huldah Davidson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 189 Jenkins Pond Rd. Milford, De. 19963 19e. Informent's Neme/Reletionship (Type, Print) Hazel H Willis/Wife 20b. Pleca of Disposition (Name of cemetery, crematory or other plece) Barratts Chapel 20e. Method of Disposition 20c. Location - City or Town, State 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State 7-3-98 Frederica, De 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Fecility Rogers Funeral Home, 301 Lakeview Ave. Milford, DE. 19963 100 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) LUNGESTIVE ACART FAILURE 3 DAY) Due to (or es e consequence of): 3 PAYS SUBENDO LARDIAL MI Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): ASCUD Due to (or as a consequence of): Pert II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Dinknown INSUFFILIENCY RENAL 24b. Were autopsy findings aveilable prior to 24a. Wes en autopsy performed? EA OF PROSTATE completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicel examiner? 1 ☐ Yes 2 ♣No 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury et Work? 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide 29a Certifier 1 Scertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner as steted. 2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier

State Registrar

Physician

/Medical

Examiner

Director

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7 is marked other than "naturel", or items 23s or 28s-f ebov traumstic event, the Modical Examinar must be notified at

nit. Peges 1 and 2 should be filed within 72 hours efter deeth with serment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "naturel", or items 23s or injury or other traumatic event, the Medical Example manages.

Department of Important: If any Injury or

Physician

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Examiner

that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

BURTON

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

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Baltimore, Maryland 21215-0020

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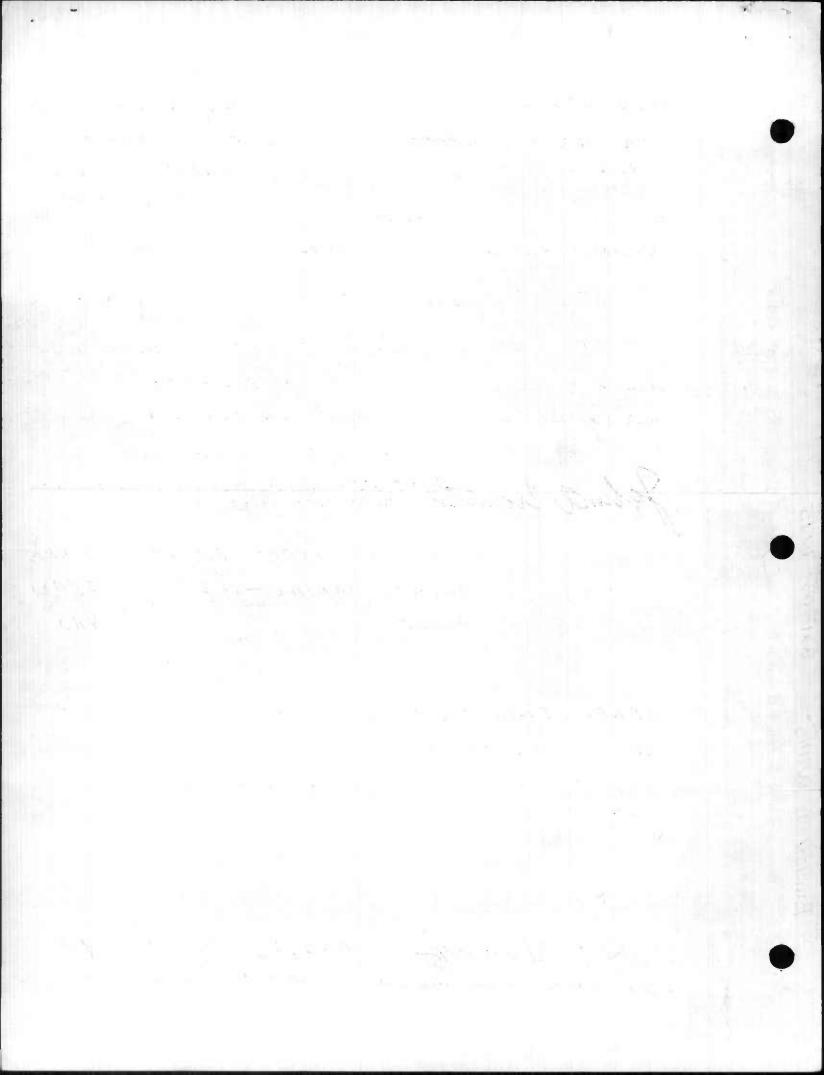
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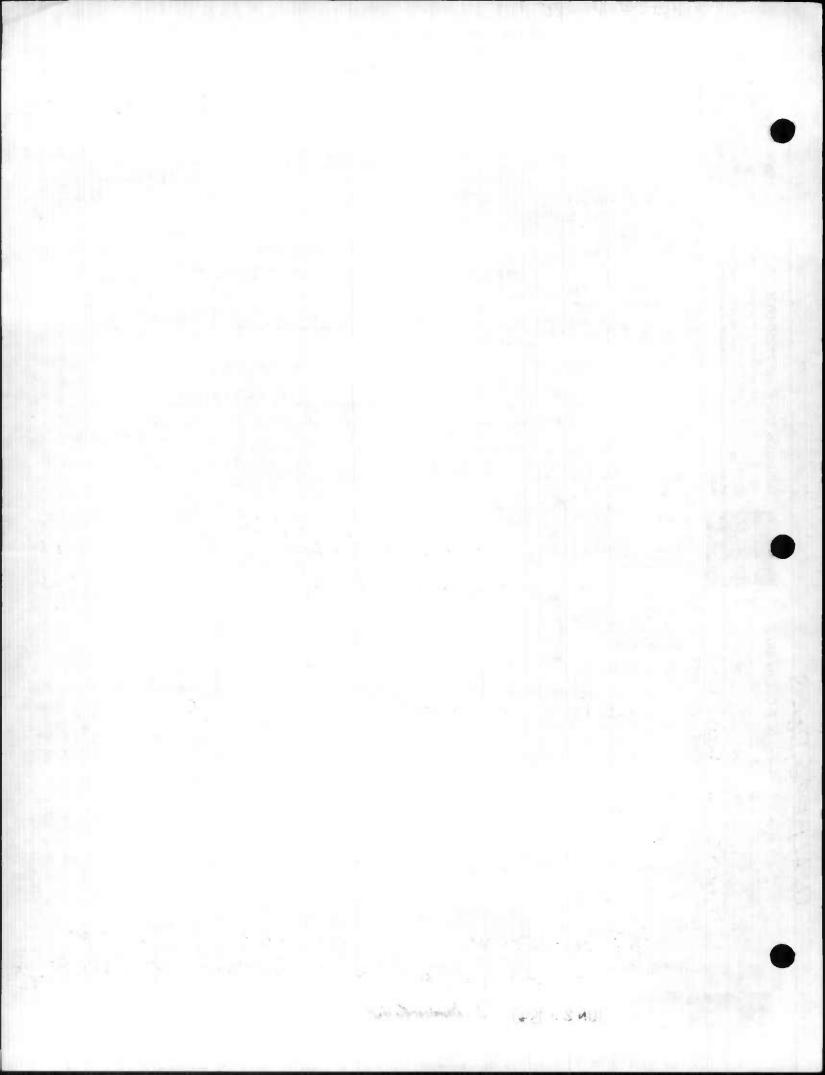


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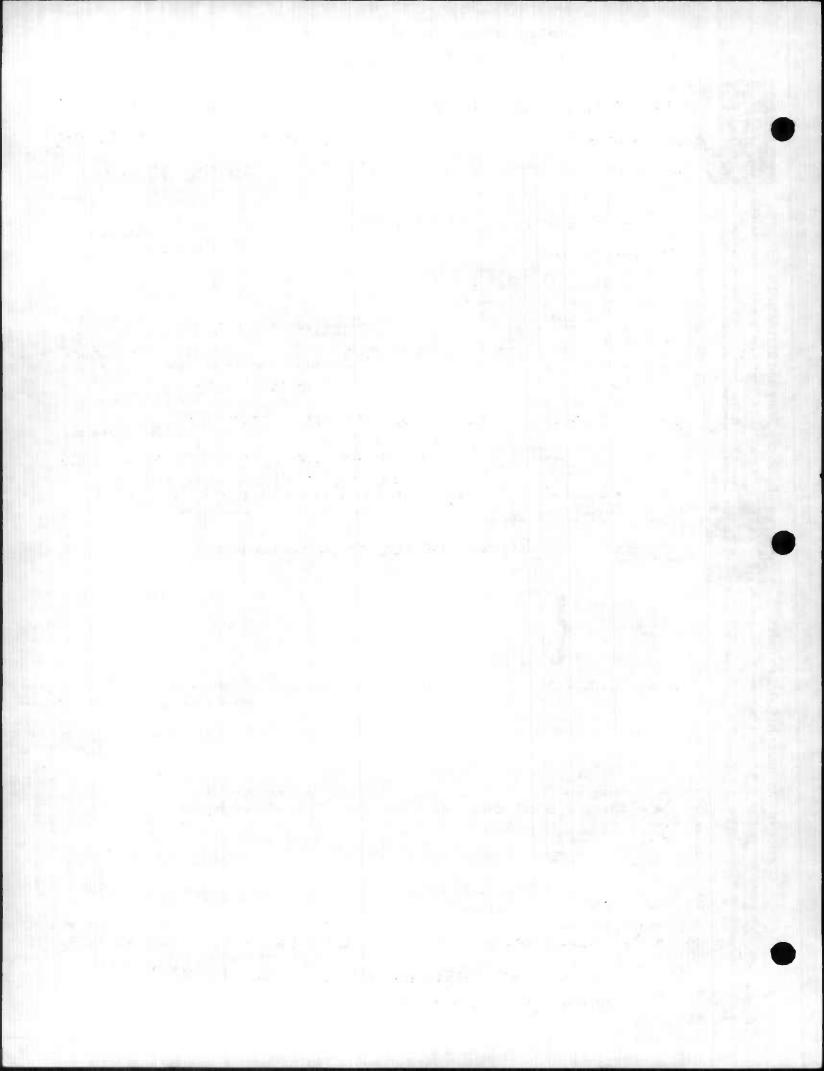
State of Maryland / Department of Health and Mental Hygiene

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	Physic /Med		Doris Je	ean Walk	erg						6	25	75	14 pm
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			Carroll	County	Hospital					Westmins				Carroll
	Funera Directo		5. Social Security N 232-42-7	7233	3. Sex 1 M 2 F	7. Age (In yrs.		nday) If Undi Months	er 1 Yea Dey		in. (Month,	Birth Dey, Year)	9. Births	place (Stete or Foreign http) W.VA.
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	e Maryle	Director	MD	Carroll			mins	ster						1 ☐ Yes 2 No
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	D and and and and and and and and and and	Be (17. Father's Name	(First, Middle, L.	ast)					18. Mother's N	lame (First, Midd	fle, Maiden Sume	ne)	
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	Par and and is m		19a. Informant's N				19b. l						city or Town, State, Zip Code)	
	and and n 27		20e. Method of Disposition 20b. Place of Disposition (Name of						_					
	Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 28 or 284-7 show any injury or other traumatic event, the Medical Eram est must be notified at once. To Be Completed by Funeral Director		1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery, cremetory or other place) Evergreen Memorial Gard								dens			burg, MD
			21. Signeture of Fu	ineral Service Li	cansee	22-Name and Address of Facility					Rd., Westminster, MD 21157			
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V	Vision Attending or death.	1월	2 Accident	5 Pending Investiga	ition	,,		М		☐ Yes 2☐ No				
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State of Maryland / Department of Health and Mental Hygiene 98 2 | 6 5

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Physician /Medical	1. Decedent's Name (First, M	DORAN	210	Hea				3	Date of De Month	7 C) 499 8	3. Time of Death	
Examiner	4a Facility Nama (If not instituted as \$380 CHISWICK		nd number)				4b. City, Tov				of Deeth	MORT	
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Physician /Medical Examiner Examiner Examiner	Immediate Cause (Final disease or condition resulting In death)	a. <u>Pu</u>		ua to (or as a c	onsaquanc	e of):	180 BW	Bocisi	sn				
certificate be executed nding physician and use as the buriel-transit n/Medical Examir	Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last	c		e to (or es a c									
	Pert II. Other significant con-	ditions contributing	g to death but i	not resulting In	the underly	ring cause gi	iven in Part I.	Part I. 23b. Did tobacco use contributs to the cause of de				the causs of death	
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certificate hes rector, page 2 Be Comp	25. Was case referred to med	dical					26 Place	of Death //	1 🗆		1[Yes 25 No	
# F 5 W	examinar? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nu							rsing Home	ath (Check only ona) Home 5 Residenca 6 □Other (Specify) 28d. Describe how injury occurred				
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To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this or completely filled in by the funeral director. After this completely filled in by the funeral director and the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for function for the funeral director for function for functions for functions for functions for function for functions for function for function for function for function for function for function for function for function for function for function for function for function for function function for function for function for function function for function funct	27. Manner of Deeth 1 Natural 2 Accident 3 Suicida 4 Homicide 29a. Certier 1 Certier 29a. Manner of Deeth 1 Certier 25 Medi	nding astigation uld not be termined 28e. Ifying Physician: 7 cal Examiner: On encitifier	Place of Injury building, etc. (To tha best of r the basis of end d manner stete	(Specify) my knowledga, kaminetion and d.	m, streat, for daath occurrences	ectory, office	ime, date sno opinion, deal	d pleca, and	City or To	ceuse(s) and me dete and place,	enner as s and due to	tated. the cause(s) Day, Year)	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 4c. County of Death ANDREW DUNNE AYRES JR. 12:05 PM 4b. City, Town, or Location of Death Saint Joseph Medical Center Towson Baltimore Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) April 22,1931 Baltimore, Md. 5. Social Security Number If Under 1 Year 6 Sex 7. Age (In yrs. last birthday) 1₽M 2□F Months Deys 213-26-3898 67 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Co. Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of Whel Country? 65 Northwood Drive 21093 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 20 Merried 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Machinist Clark Machine Corp. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Andrew Dunne Ayres, Sr. Edna Viola Johnson 19a. Informent'a Neme/Reletionship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Grace Jean (nee McCann) Ayres 65 Northwood Drive Timonium, Maryland 21093 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta WBurial 2 Cremetion 3 Removel from Stete Parkwood Cemetery 7/14/98 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 21. Signeture of Funerel Service Licenses Jeffrey L. Gair aus 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leiture. List only one cause on each line. Approximate Interval Between Onset and Deeth tmmediete Cause (Finel disease or condition resulting in death) SEPSIS 28 DAYS Due to (or as a consequence of). NECROTIZING FASCIITIS 28 DAYS Due to (or es a consequence of): Due to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 Yes 2 No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Directo

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Completed

Be

Funeral

Director

than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

"natural", or

filed within 72 hours after Hygiene. ther then "natural", or its

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If hem 27 is marked other any injury or other traumatic event. It

Baltimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.

or Attanding Physician:

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Director:

a Funeral Dire letaly filled in b

the Maryland

Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last 9 edical Physician/M

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Completed

8

Certification: To

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical examiner? Hospitet: Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of

28a. Dete of Injury (Month, Day Year) 1 Netural 2 Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide 4 Homicide

Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 28d. Describe how Injury occurred 1 Yes 2 No

281. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner es stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated.

29a. Certifier (Check only one)

29c. License number D25886

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

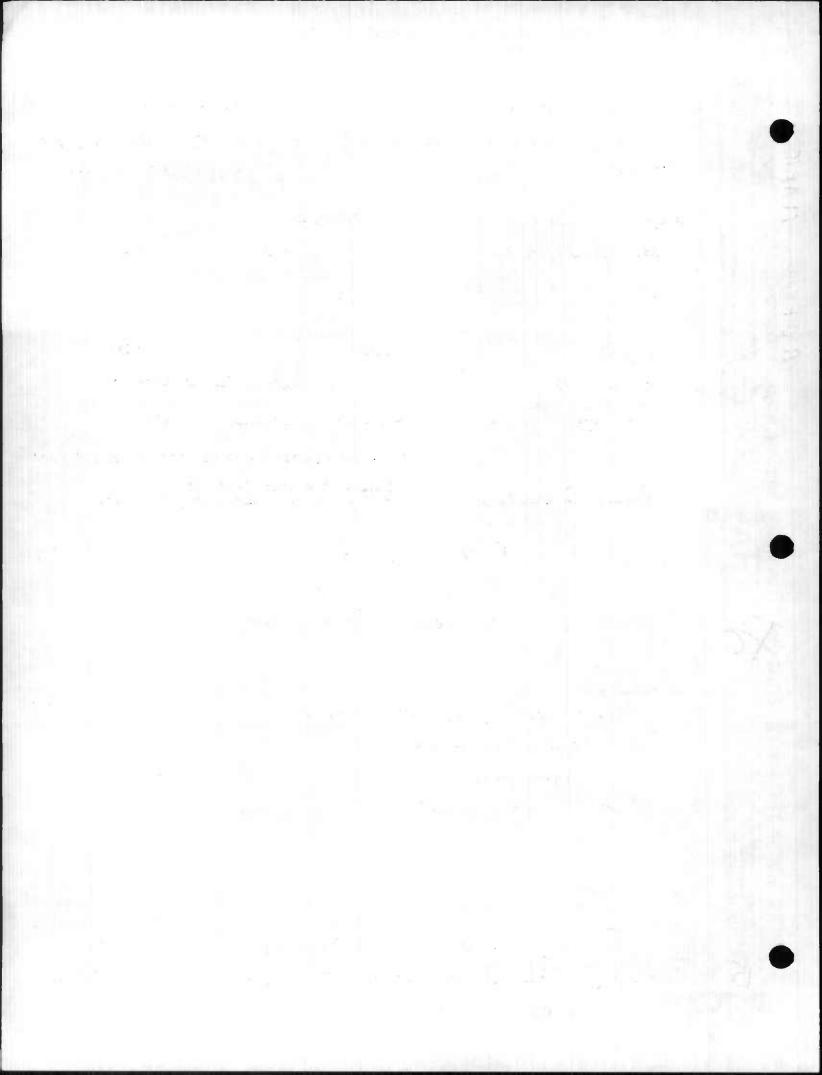
ILIA CEBALLOS M. D.

7620 YORK ROAD TOWSON, MARYLAND 21204 32. Registrer's Signeture hia Davidson-Randage

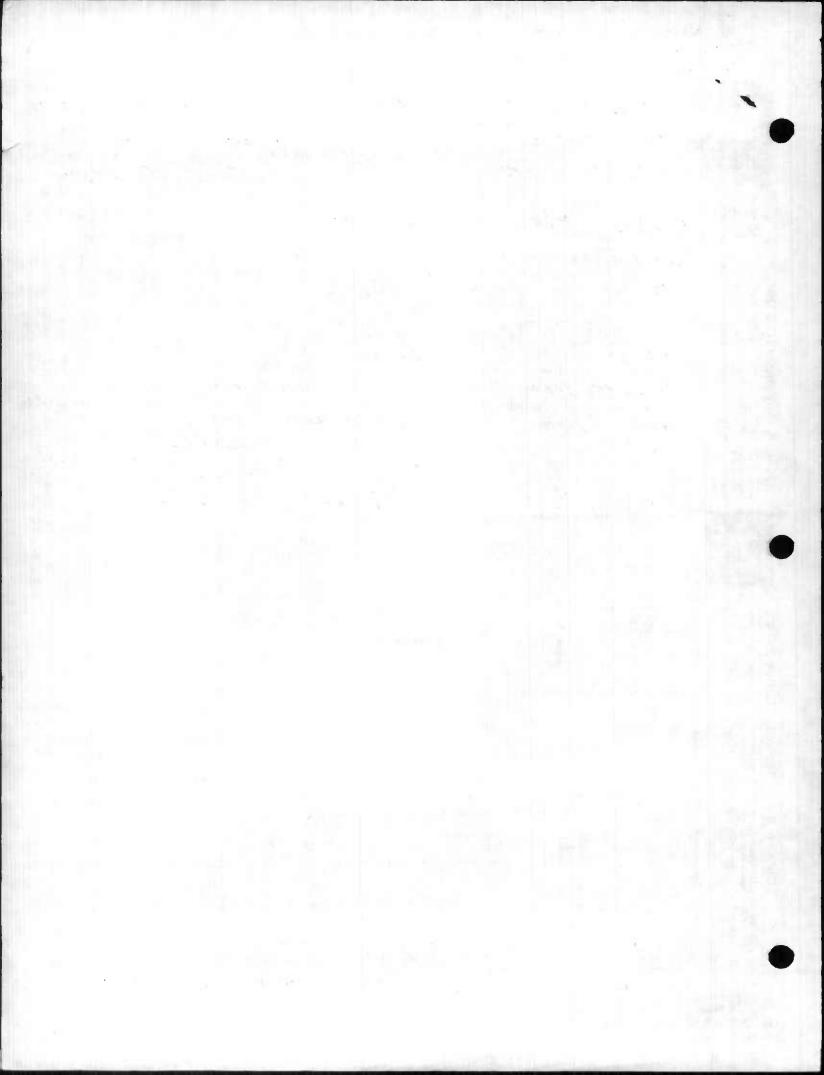
State Registrar

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 6 6 0

by Funeral Director	4a Fecility Name (If not institution, give FLAPKUL SQU 5. Social Security Number 6. S.	rows						e of Deeth			3. Time of Death
/Medical Examiner uneral rector	4a Fecility Name (If not institution, give FLAPKUL SQU 5. Social Security Number 6. S.							nth _	Dev	Yeer	111 0
xaminer neral ector	FRANKUL SQU 5. Sociel Security Number 6. S.	4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death FRANKUR SQUARE (HOSPITAL CENTER ROSEDALE BALT)									4:00 8
rector	5. Sociel Security Number 6. Se	street end number)							-		
ector	5. Sociel Security Number 6. S	ARE HOSI	PITA	LCE	NTER	Ro	SEDA	-E	B	ALT	INORE
facial	137-28-3072	7. Age	99	st birthdey) Yrs.	If Under 1 Yes		Min. 8. Det Min. Aug	of Birth nth, Day, Ya	1898	9. Birthplec Country Mary	e (Stete or Foreign Land
to	Usuel Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation					10d.	Inside City Limits
	Maryland Baltimo	ie			Balt	imore					1 ☐ Yes 2 🗖 No
ire is	10e. Street and Number				10f. Zip Code			10g.		What Country	?
6	6841 Queens Fe	vry Road				212	239		u.s.	.A.	
by Funeral Director	11. Meritel Stetus 1 Never Merried 2 Married 3 X Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:			Was Decedent on the state of t		gln? (Specify Ye , Puerto Rican, (s or No- etc.)		e - American ck, White, etc :: Whi	
P P	15. Decedent's Ed (Specify only highest gre	ucetion		16a. Dece	dant's Usuai Occ	cupation ne during most	t of working	16b. Kind of Businass/Industry			try
Completed	Eiamentary/Secondary (0-12) 12th grade	College (1-4or 54	+)		kind of work dor DO NOT use reti nemaker	ired)			Own	Home	
To Be Compl	17. Father's Neme (First, Middle, Last) Martin Mik					18. Mother	r's Name (First, nes (Su	Middla, Mai LNAME			
-	19a. Informant's Name/Ralationship (7	ype, Print)		19b. Maili	ng Address (Stre	et end Numbe	er or Rural Route	Number, Ci	ity or Town,	Stete, Zip Co	ode)
3	Dolores Mayer	(niece)		1292	6 Fork	Rd., Bo	aldwin,	MD 2	1013		
į	20a. Method of Disposition		20b. Piace of Disposition (Neme of cemetery, crematory or other place)					Dete 20c. Location - City or Town, Stat			, State
	1 ABurial 2 Cremetion 3 4 Donetion 5 Other (Specify		cemetery, crematory or other plece)					7/15/98 Baltimore, Maryla			
once	21. Signeture of Funerel Servica Licen	Willem	1	- 9	2. Name and Add Schimune 1705 Bel	k. Funer	ral Home	, Inc	้นก	01024	
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cian lical iner	Immediate Ceuse (Final disease or condition resulting in death)				Fai					0	terval Between nset end Death
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n/Medical	resulting in death) Lest	d	3 10) 01 600	as e consec	querice or).						
sicia	Part II. Other significant conditions co	ntributing to death but	t not resuit	ting in the u	inderlying ceuse	given In Pert I.	. 23	b. Did toba	cco uee co	ntribute to th	e cause of death
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eted a	Senil	e de	men	h'a			24	e. Was an a performed	utopsy 1?	24b. Were availa comp of dea	autopsy findings able prior to letion of cause ath?
o Be Comple	A	remin						1 🗆 Yes	20 No	1 D Y	es 2□ No
BeC	25. Was case raferred to medical					26. Plece	of Death (Chec	k only ona)			
ToE	examiner?	Hospitel:	nt 20E	R/Outpatie	nt 3 DOA	Other: 4 Nu	rsing Home 5	Residenc	e 6 Oth	er (Specify)	
tion:	27. Mannar of Daath 1 Defatural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Dey	npatient 22 EN/Outpatient 31 DOA 41 Nursing H					scribe how	Injury occur	red	
Certification:	2 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street end Number or Full building, etc. (Specify) 28f. Location (Street end Number or Full City or Town, Stete)									per or Rural R	loute Number,
completely filled in by the funeral director, Medical Certification: To Be (29a. Certifiar 1 Certifying Phy (Check only one) 2 Medical Exam	raician: To the best of Iner: On the besis of end manner stat	examination	ledga, deet on end/or in	h occurred at the vestigetion, in m	time, data and y opinion, deat	d place, and due th occurred et th	to tha caus e time, date	a(s) and ma end piece,	annar as state and due to th	ed. e cause(s)
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) Ling	- MD			0	4373	20		71	1219	4
	30. Name and address of person who of	•	eath (Item 2	23a) (Type,	Print)	2	2	N Carlo	2	, Bul	himore D 2122

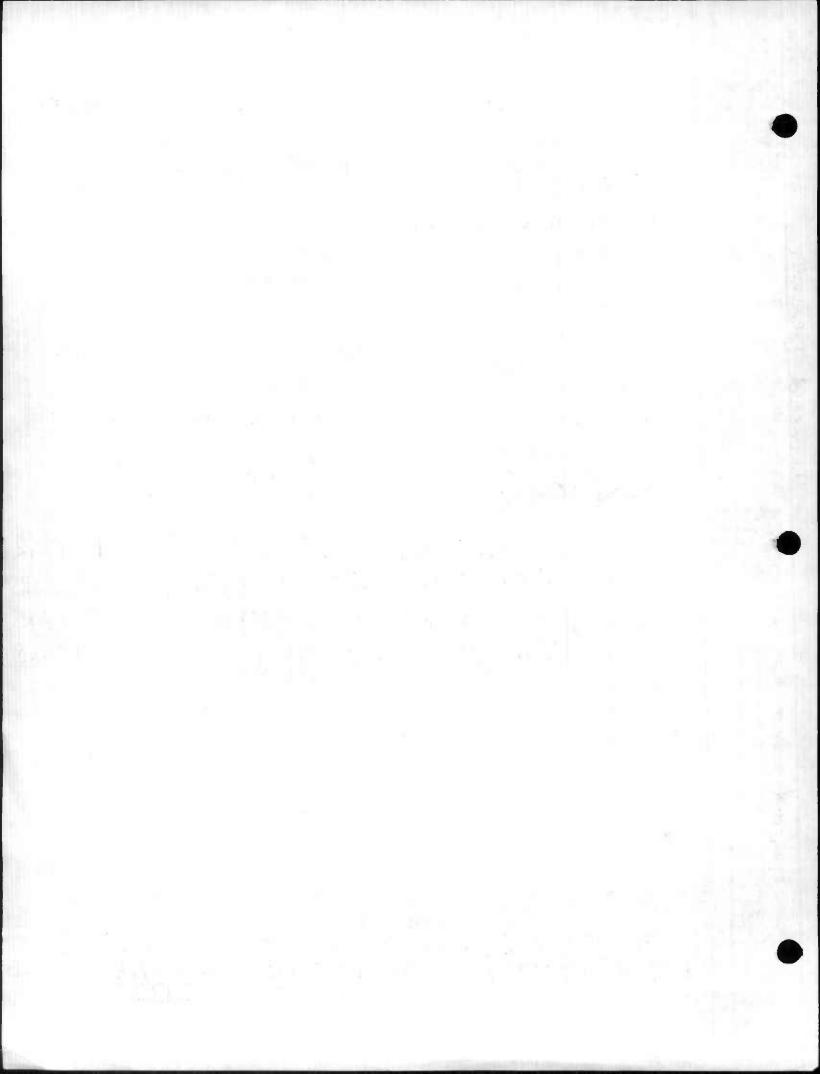


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	EMS: #23 PART I, 27, 28A	State of Marylan	d / Department of 7-28-98 WR Certificate of	Health and Ivie f Death		50	21661
	1. Decedent's Nama (First, Middle, Last)	-F PER MEU 9/01	Certificate of		Reg 2. Data of Death	. No.	3. Tima of Death
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/Medical Examiner	4a Facility Nama (If not institution, give s	treet and number)		4b. City, Town, or Loc		4c. County of	
	2208 E. NORTH AV			BALTIM		^	J/A
Funeral Director	217 12 0001	7. Age (In yrs. 39	last birthday) If Under 1 Yes Months Day	s Hours Min.	B. Data of Birth (Month, Day, 1)	1959	9. Birthplaca (State or Foreign Country) Hoyy/mx
show Man	Usual Residence of Dacedent 10a. State 10b. County	10c. Cit	y, Town or Location		,		10d. Inside City Limits
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With your D	10a. Street and Number 2208 E. North	W Bux	10f. Zip Code	212/3	10	g. Citizen of W	
death		Was Decedent Evar in U, Armed Forcas?		f Hispanic Origin? (Specuban, Mexican, Puerto R	ify Yas or No-		- American Indian, k, White, etc.
D2(1 Wever Married 2 Married 3 Widowed 4 Divorced	1 Yas 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 2N		ican, etc.,	Specify:	1
72 hound 72 hound and and a seed b	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's Usual Occ (Giva kind of work dor	upation ne during most of workin ired)	7	6b. Kind of Bu	siness/industry
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be filed to their dother, usent, use Co	17. Father's Name (First, Middle, Last)		HOLKENKIE	18. Mother's Neme	(First, Middle, M.	aiden Sumem	θ)
ylan ould be Mentel marked c	GARNEH BARN	VES		WilliE 7			
Aar 2 sh and and sh	19a. Informant's Name Wilationship (Typ	e, Print)	19b. Mailing Address (Stre	et and Number or Rural	Route Number,	City or Town,	State, Zip Code) 2/2/8 HUNE Hd
5 6 8 7	20a, Method of Disposition	20b. P	lece of Disposition (Name of				City or Town, State
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Baltimore, permit. Peges 1 a Depertment of He Important: If them any injury or other once.	21. Signature of Funeral Service Viginise		22, Name and Add	ress of Facility CA	TUIAN	- Hom	s Knerd Home
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Physician / /Medical	Immediate Cause (Final						Onset and Death
Examiner	disease or condition resulting in death) e.		INTOXICATION CON	MPLICATING CHR	ONIC NARC	OTISM	
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687 tifficate g phys es the	resulting in death) Last	Dua to (or	r as a consaquance of):				
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. 0 00 0	Part II. Other eignificant conditions cont	ributing to death but not res	ulting in the underlying cause	given in Part I.	23b. Did tob	acco use con	ntributa to the cause of death?
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Records, P.O. to law requires that the law requires that the shes been signed by those 2 should be detected by Physompieted by Phys					24a. Was an	autopsy	24b. Were autopsy findings
al Record The law require ale hes been sign page 2 should t					perform	ed?	available prior to completion of cause of death?
The law ate hes pege 2					1 2 (Yes	2 □ No	1 12 Yes 2□ No
Vital Factor The certificate lirector, peg	25. Wes case referred to medical examiner?	analenti		26. Place of Deeth	(Check only one)	
of Vita Physician: this certific ral director,	1 N Yes 2 No	28e. Dete of Injury	ENOutpatient 3LI DOA	Other: 4 Nursing Hom	e 5XXResider 8d. Describe hov		
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Hospita 24 hours Funeral Mely filled	29a. Cartifier 1 Certifying Phyel (Check only one)	clan: To the best of my kno	wledge, death occurred at the tion end/or Investigetion, In m	time, dete and plece, as y opinion, deeth occurre	BALTIMORE nd due to the car d at the time, da	use(s) and ma	nner as stated. and due to the cause(s)
To the within To the comple	29b. Signeture and title of cartifier	and mainer stated.	29c. Lice	rise number	29	d. Dete signed	1 (Month, Dey, Year)
->-0	Atunh A	Man	Les mo	O.C.M.E.	J	ULY 10	, 1998
	30. Name and address of person who con	npleted cause of deeth (Item	ase) (Type, Print)				
	Stephen S. R		11 Penn Stree	t, Baltimor	e, Mary	land 2	1201
State Registrar	31. Dete filed (Month, Day, Year) JUL 151998	32. Registrar's Signa	ture				
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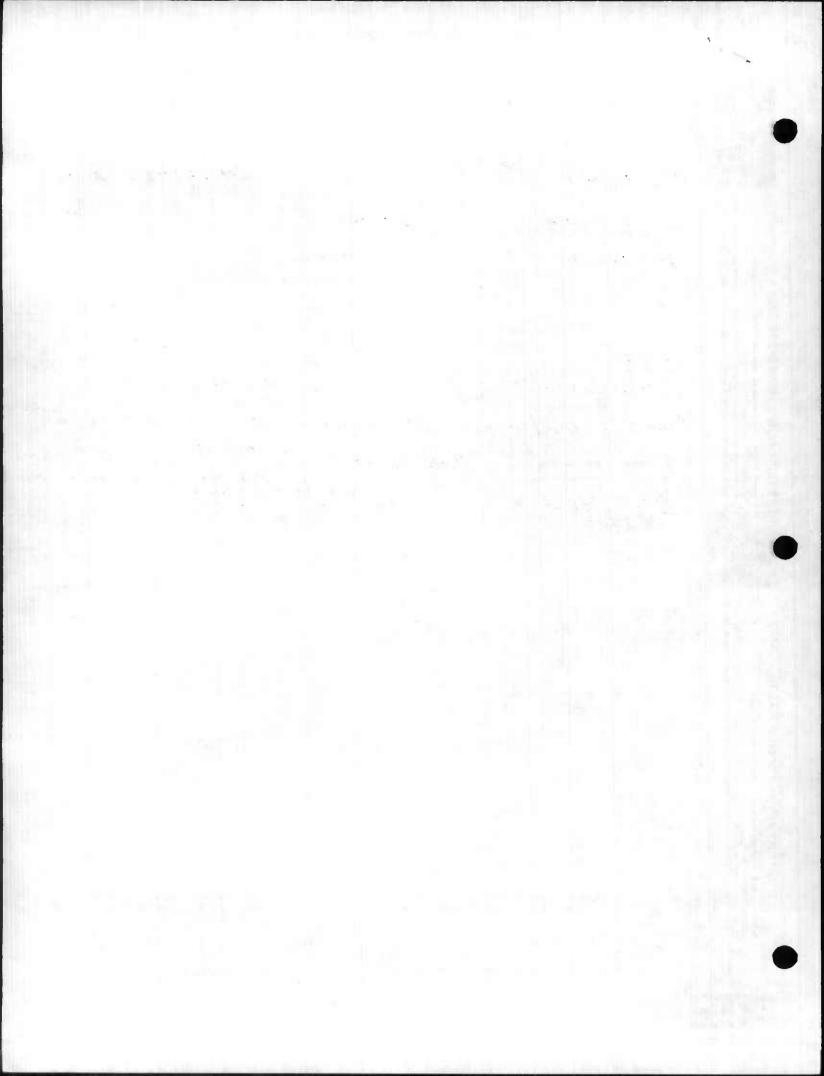
State of Maryland / Department of Health and Mental Hygiene O O

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4	/Medi		Leonard	R.		Bessette		JULY	11, 1997	5 610 PM	
9	Examir	ner	4a. Facility Nama (If not institution, giva street and number)				4b. City, Town, or Location of Death 4c. County of Death				
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglere. Important of Health and Mertall Hyglere. Important if flow 27 is merked offber than "natural", or items 23a or 28a-1 show any injury or other traumetic event. the Modisal Examiner must be notified at once.		10a. Stata 10b. County	or Location	Location			10d. Insida City Limits			
		tor	Maryland Anne Arundel			Pasadena				1 ☐ Yas 2 🕱 No	
		Funeral Director	10e. Street and Number		, , ,	10f. Zip Coda		1	log. Citizan of What C	ountry?	
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020		by	1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowad 4 ☐ Divorcad	1 Xyas 2 N If Yas, Giva Yaar or Datas:	US Army	1 ☐ Yes 2 ☐ (No		to moun, atc.,	Specify:	White	
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			Elementery/Secondery (0-12)			16a. Decedant's Usual Occupation (Giva kind of work dona during most of works lifa. DO NOT use retired)		iking			
21			12			Truck Driver			Auto Parts Deli		
and			17. Fathar's Nama (First, Middla, Last)			18. Mother's Name (First, Middla, Maidan Sumama)					
yla			Lawrence Bessette Doroth								
Maryland								er or Aural Routa Number, City or Town, Stata, Zip Code) and Ct. Pasadena, MD. 21122			
6			20a. Mathod of Disposition	71 Tella	20b Place of			Data Data	20c. Location - City o		
0			1 XBuriai 2 ☐ Cremation 3 ☐			Disposition (Nama of v, cramatory or other plants					
altimore			4 Donation 5 Other (Special		Ledar	Hill Ceme			Glen Burni	e Maryland	
Ba			21. Signatura of Funaral Sarvice December 22. Nama and Addrass of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena, Maryland 21122								
	To the peptial or Attending Physician: The law requires that the death certificate be axecuted XIII and death careful principles. After death of the title and principles and XIII and peptial principles. After this certificate has been signed by the attending physician and XIII and peptial principles. After this certificate has been signed by the attending physician and XIII and peptial principles. After the funeral director, page 2 should be detached for use as the burial-transit of the boundary and the peptial p	Examiner	23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only	plications that caused one cause on each lir	tha daath. Do n	ot anter tha moda of dy	ing, such as cardia	or respiratory arr	ast,	Approximate Interval Batween	
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68760,			Cause (Disaasa or Injury that Initieted events	Due to (or es a consaquanca of):					ILAK		
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Вох			Don't Other storids and an atti				DISEASE				
of Vital Records, P			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death?		
								1/4	1 Yes 2 No 3 Probably 4 Unknown		
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									. V.	of death?	
			25. Was casa refarred to medical				ac Blass of Da	1 Y		1 ☐ Yas 2 ☐ No	
		o Be									
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		atio	1 Naturel 5 ☐ Panding 2 ☐ Accidant investigatio	(Month, Day Year) Injury Work? on M 1 □ Yes 2 □ No							
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ā		Cer	· La rivillo	building, atc. (Specify)							
1		edicai	29a. Cartifier (Check only one) 1 Certifying Physician: To the best of my knowladga, daath occurred at tha tima, data and place, and dua to the ceuse(s) end manner as stated. 2 Medical Examiner: On the bests of axaminetion end/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) end manner stated.								
1		Me	29b. Signature and title of certified ATTEND (NO 29c. Licansa number 29d. Data signed (Month, Day, Year)								
			PHYSICIAN DI4160 JULY12, 1998 30, Name and addisess of person who compressed pause of pleasy (Itam 222) (Types Print) A RITCHIE HIGHWAY, BALTIMORI								
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8			MARYIAND 21225								
	Sta Registr		31. Data filed (Month, Day, 1942) 15 1998 32. Registrar's fignature Aunder Anders								



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	1. Decedent's Name (First, Middle,	Last)	Certii	ficate of	Dealli	2. Dete of Dee	Reg. No.	3. Time of Dea
sician	CORA BA	,				Month J.J.		'ear
ledical	4a Facility Neme (If not institution,				4b. City, Town, or I			
aminer		enich centel			Ballimon	<	Beth	
eral tor	5. Sociel Security Number 0.73 - 20 - 5309 Usual Residence of Decedent	5. Sex 7. Age (In yrs 1		f Under 1 Yeer fonths Days	If Under 24 Hrs. Hours Min.	8. Dale of Birth Month, Dey	, Year)). Birthplace (State or Fo Country)) - Caro Lina
H .	10e. Stete 10b. County	10c. C	City, Town or Locati					10d. Inside City Li
ctor	Maryloso U/	4	Balti	non				1-XTes 2
Director	10e. Street end Number	1. 1		10f. Zip Code	20		10g. Citizen of Wh	
aral	802 Walnu	A HUA	110 140 146	2120		anife Van as Na		American Indien,
by Funeral	11. Maritel Sielus 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever In Armed Forces? 1 Yes 2 Yes Very Year or Dates:		es, specify Cub	dispenic Origin? (S an, Mexicen, Puert Specify:	Rican, etc.)	Black,	While, etc.
	15. Decedent's	Education	16e. Decedent	t's Usuel Occup	pation		16b. Kind of Busi	
Completed	(Specify only highest Elementery/Secondery (0-12)	grede completed) College (1-4or 5+)	(Give kind life. DO		during most of word)	king	Private	. Frmiles
To Be C	17. Father's Name (First, Middle, La FESTER MAS		-1		18. Mother's Nam		Meiden Sumame)	
-	19a. Informant's Name/Reletionshi		19b. Mailing A	Address (Street	end Number or Ru	rel Route Numbe	r, City or Town, Si	lete, Zip Code) 2/2
	Bennie J. Alle	NEPHEW	4747	Homes	DALE AUG	: BAll	HIMER, A	eary to
y or offi	20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Spe	Hemoval from State	Place of Disposition cometery, cremeter BADI	on (Neme of ony or other ple	ce)	7-18-98	20c. Location - C	lary lass ity or Town, State N. Caroli
and min	21. Signature of Funeral Service Lie	0700	52 N	ame end Addre	s TEV STEV	IN LUZA	Homis	FUNERAL HOT
	231. Part1 Enter up disease, or co	omplications that caused the dea			ng, such as cardiac		rest,	Approximete
ian	shoot, or heart failure. List or	nly one cause on each line.						Interval Betwee Onset and Dea
cal	immediate Cause (Final disease or condition		METABOLIC	Aca 003	i			hours
ner	resulting in death)	0.	(or es e consequer					
Examiner		- b	RENAL F	ALLUFE				PAYS
хаш	Sequentially list conditions,	Due to	(or es e consequer	nce of):				
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ician/Me	Part II. Other significant condition	s contributing to deeth but not re	sulting in the unde	ntvina cause ai	ven in Part I	23b. Did t	obacco use conti	ribute to the cause of d
y Physic				riying occord gr		101	1	Probably 4 Un
page 2 should be detached for use completed by Physician/M						24a. Was perfor	an autopsy med?	24b. Were autopsy find available prior to completion of caus of deeth?
Comp						101	es 2 No	1 ☐ Yes 2 No
Be C	25. Was case referred to medical				26. Place of Dec	th (Check only o		,
2	examiner?	Hospital: 1 Ninpatient 2[☐ ER/Outpatient	3 DOA ON	her: 4 Nursing H	ome 5 Resid	lence 6 Other	(Specify)
DD:	27. Manner of Death 1 ≥ Natural 5 □ Pending	28a. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe h	now Injury occurred	d
catic	2 Accident investiga	tion MA-		M 1	Yes 2□No			
edical Certification:	3 Sulcide 6 Could no determin		home, ferm, street, cify)	, fectory, office		28f. Location (5 City or Tox		or Rurel Route Number
) al		Physician: To the best of my kn caminer: On the basis of examin and manner stated.						
	20h Clanatura and title of contifier	n M		29c. Licens				(Month, Day, Year)
Medic	29b. Signeture and title of certifier	2 0/1 1		0.0	7113		JU17 1	5 1500
Medic	Page 1 and the or certifier	101)		0.3			3-1	, , , , , ,
	30. Name and address of person w	no completed cause of death (Ite	em 23e) (Type, Prir 30; St ('a	nt)	Belhmore	Wis On		2, 1110



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🎗 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 12:45 pm 998 Janice Estella Boothe 4a. Fecility Neme (If not institution, give street and number) 4b. Gity, Town, or Location of Deeth timore sugue. 8. Dete of Birth (Month, Dey, Year) May 19,1924 If Under 1 Yeer 5. Sociel Security Number Linde 9. Birthplece (Steta or Foreign County)
Mississippi 7. Age (In yrs. last birthday) Deys Months Hours 1□M 2/2 F 251 28 4722 74 Usuei Residence of Decedent 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Essex 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2119 Silver Lane 21221 USA 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Rece - American Indien, Bleck, Whita, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 XNo Specify: 3 XWidowed 4 Divorced White 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Coilege (1-4or 5+) Housewife Own Home 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) Robert. Smith Fanny Chestine 19a. Informent's Neme/Raletlonship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Linda Facello (daughter) 2119 Silver Lane Essex, Maryland 21221 of Disposition (Name of Disposition (Name of Dete 20c. Location - City of 20c. Location - City or Town, Stete 20e. Method of Disposition 20b. Plece of Disposition (Name of camatery, cremetory or other plece) 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetlon 5 ☐ Other (Specify) Crest Lawn Cemetery 7/15/1998 Howard County Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23e. Part1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, should, or heart failure. List only one cause on each line. Approximete Intarval Between Onset end Deeth Immediate Causa (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 No 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24a. Was an eutopsy periomed? 1 2 Yas 2 No 1 Yes 20 No 28. Piaca of Daath (Chack only ona)

Physician /Medicai Examiner

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within 24 hours efter death. To the Funeral Director: A

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Certification: To

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The lew requires that the death certificete be executed

Box 68760.

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Division of Vital Records,

or Attending Physician:

Hospital

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show unotified at

than "natural", or items 23s or : the Medical Examiner must be n

opartment of Health and Mental Hygiene.
Important: If them 27 is mented other ending any injury or other trausers.

Director

Funeral

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Examiner Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Ceuse (Disease or Injury that initieted avents resulting in deeth) Lest Completed by Physician/Medical

Arteriolonephrosclerosis Malnutrition

25. Wes case rafarrad to madical axaminer? Hospitei: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Mannar of Deeth 1 Neturel 5 Pending Investigation 2 Accidant

28d. Describe how injury occurred 28a. Date of Injury (Month, Dev Year) 28b. Time of 28c. Injury at Work? 1 TYes 2 No

6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

29b. Signeture and title of cast

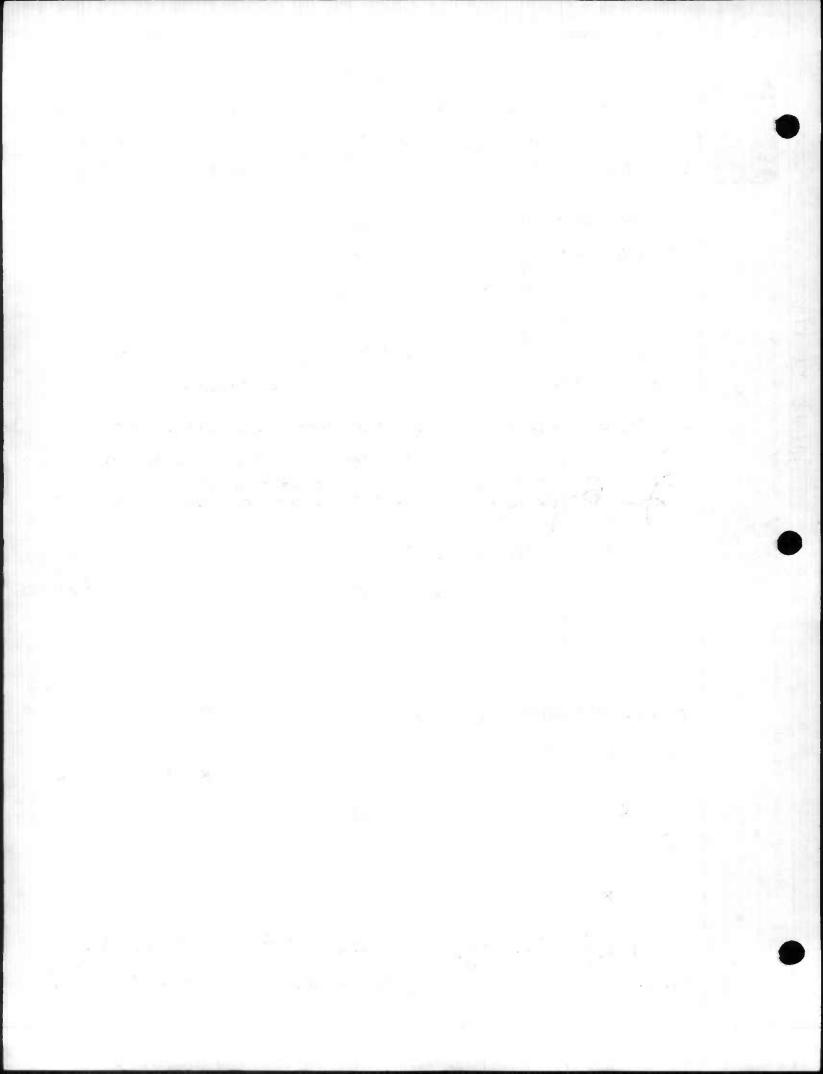
1 Certifying Physician: To the best of my knowledga, daath occurred at the time, dete end pleca, end due to the ceuse(s) and menner es ateled.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end pleca, end due to the causa(s) end menner steled.

29d. Data signed (Month, Day, Year)

ed causa of death (Itam 23e) (Type, Print)

Hatzis M.D. 9000 Franklin Square Drive Baltimore, mb naujotis 32. Registrar's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month John Edward Raker 3:00 AM Jul.y 1.0 1998 /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner VAMC FORT HOWARD DIVISION Fort Howard Baltimore If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) NOV. 21 1925 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** Days 1 □XM 2 □ F Hours Yrs. Director 206-12-1047 Maryland Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location show 10d. Inaide City Limits r than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6930 Gunder Avenue 21220 USA Funeral 12. Was Decedent Ever in U,S.
Amed Forcas?
**Dot'as 2 | No
if Yas, Giva
Year or Datas:1944-1965 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0020 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Military Policeman U.S. Army marked other important: If Health and Mental Hy, any Injury or other any Injury or other any Injury or other any Injury or other any Injury or other any Injury or other any Injury or other any Injury or other and Injury Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) George Baker Alice Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Baker (wife) 6930 Gunder Avenue Baltimore, Maryland 21220 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata Donation 5 Other (Specify) Maryland Veterans Cem. 7/13/1998Garrison Forest, Md. ature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern AVenue Essex, Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or haart failure. List only one causa on each line. Approximata Interval Betw Onsat and Death **Physician** /Medical immedi te Cause (Final 7 Yrs. Congestive Heart Failure disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner Dilated Cardiomyopathy Yrs. physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Atherosclerotic Heart Disease Yrs. P.O. Box 68760, Due to (or as a consequenca of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No Chronic Anemia Records, þ cate has been sig , page 2 should b Be Completed 24a. Was an autopsy performed? 24b. Were sutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was casa referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 12 Abertifying Physicisn: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner steted. Medical (Check only one) 29b. Signatura and titla of certifing 29c. Licensa number 29d. Data signed (Month, Day, Year) Maria . 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9600 North Point Road Fort Howard, Marcos Galicia, MD MD 21052 31. Date filed (Month, Day, Year) 1998 32. Regiatran's Signature 5 State

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Registrar

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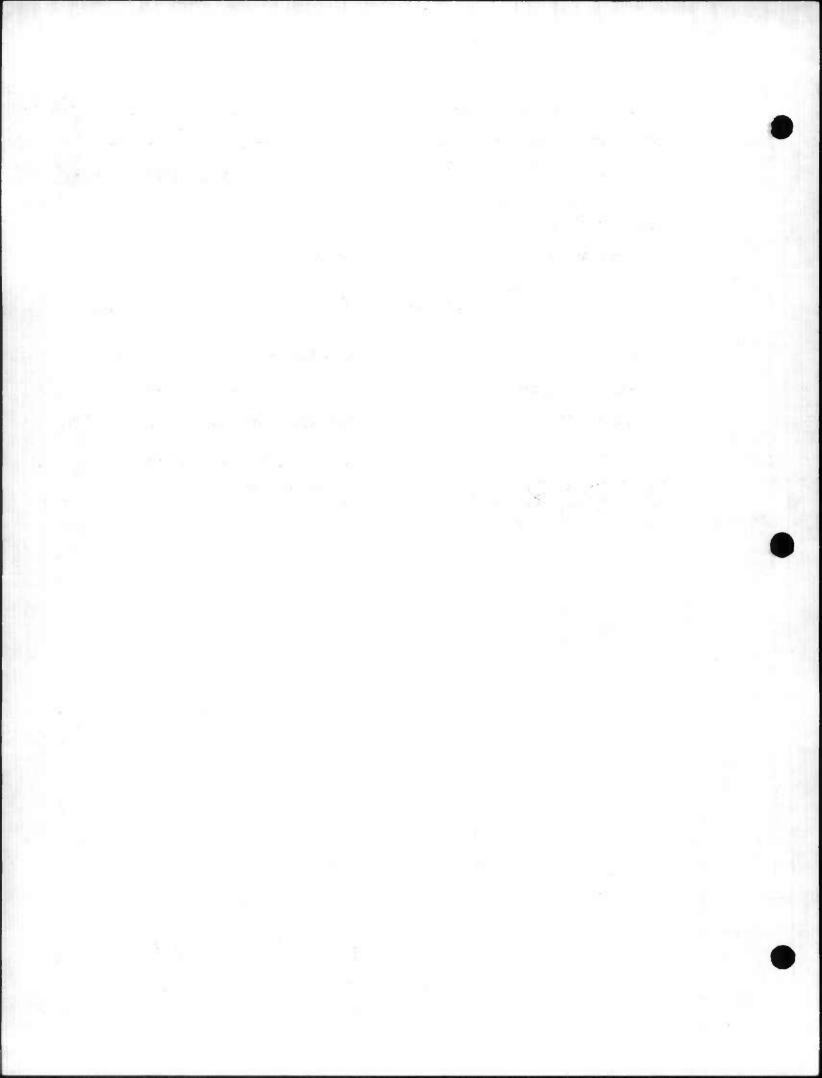
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State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) JULY 13 1998 BRADDS III ROBERT EUGENE 6:30 A.M. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) 3814 3 rd Street 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign X□M 2□F 20 Yrs. Maryland Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits Yes 2 No N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 3814 Third Street 21225 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. Never Married 2☐ Merried 1 Yes No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Student Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Robert Eugene Bradds, Sr. Mary Ann Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Hill (Mother 3814 Third Street Balto., Md. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery

22. Name and Address of Facility 7/16/98 Baltimore, Maryland 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home 237 E. Patapsco Ave. Balto., Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Concinona Due to (or as e consequence of): Due to (or as a consequence of)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

rthan "natural", or items 23s or the Medical Examiner must be r

1 and 2 should be filed within 72 hours after Health and Mental Hyglens. Im 27 is marked other than "natural", or its

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Baltimore.

5. Social Security Number

10e. Street and Number

8th

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

disease or condition resulting in death)

10a State

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Director

Funeral

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Completed

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214-90-1062

Division of Vital Records, P.O. Box 68760. certificate be 80 950 8 page 2 hes or Attending Physician: this funeral After 1 deeth. 24 hours efter deel Funeral Director: filled in by within 24 hor To the Fune completely fi 2

physician and the burial-trensit

Examine Physician/Medicai by Completed Be To Certification:

23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. Was an autopsy performed? 1 ☐ Yes 20 io 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2500 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) Matural 5 Pending 1 ☐ Yes 2 ☐ No € □ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. 29d. Dale signed (Month, Day, Year) 29c. License number

M of death (Item 23a) (Type, Print)

22 S GREENEST, 30. Name and address of person who completed ceu ESKENAZY

98

BALTIMORE HD 21201

2500

3 Probably 4 Unknown

24b. Were autopsy lindings available prior to completion of cause of death?

1 Tyes 2 No.

Registrar

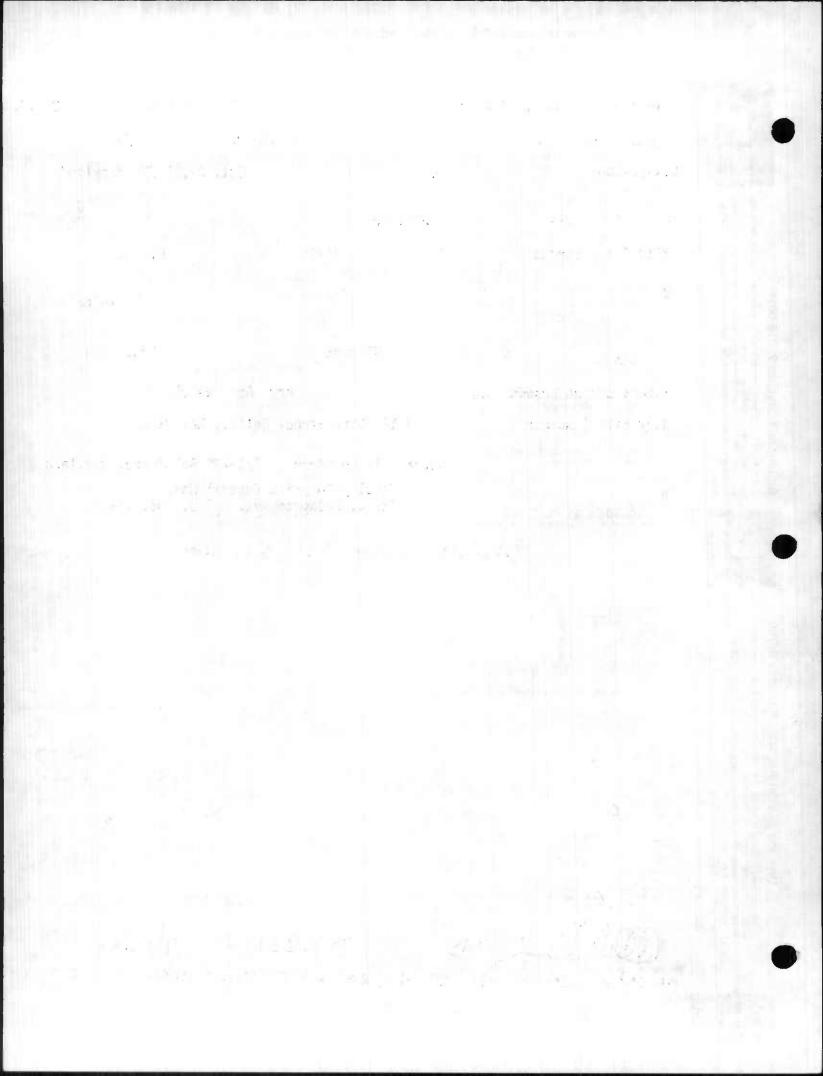
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Medical

31. Date filed (Month, Day, Year) JUL 1 5 1998

(Check only one)

32 Register's Signeture



State of Maryland / Department of Health and Mental Hygiene 98 21667

						,	Cer	tificate of	Death		Reg. No.	l _o	-1007	
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	Examine		4e Facility Neme						4b. City, Town, or L	ocation of Deet	h 4c. County	of Death		
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6	28	Director	10e. Sfreet and Nu	umber				10f. Zip Code			10g. Citizen of \	Whet Cou	ntry?	
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20 20 saft	al', or itema Examiner m	by		rled 2 Married 4 □ Divorcad	If Yes, (3 2 □ No WW	rT 4	☐ Yes 2X No	Specify:		Specify	/: W	hite	
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State Registrar

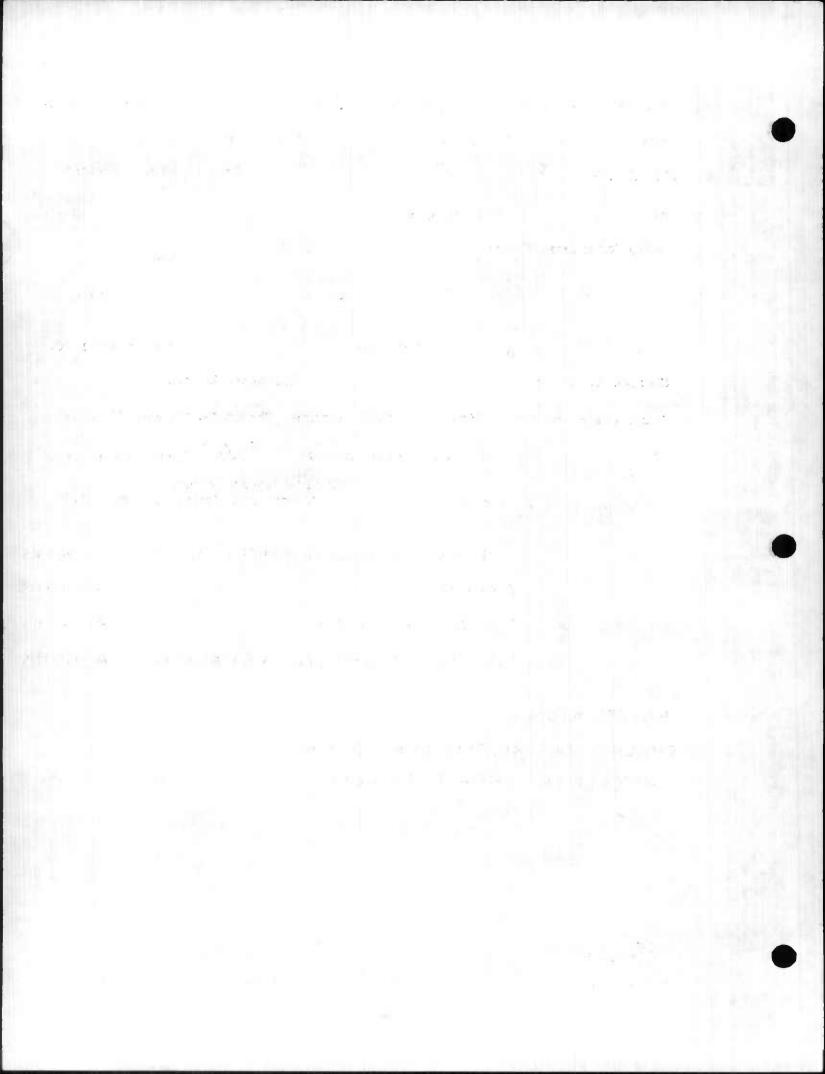
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BINDU GEORGE

HARBOR HOSPITAL CENTER,

80015. HANOVER STREET, BALTIMORE, MD 21225

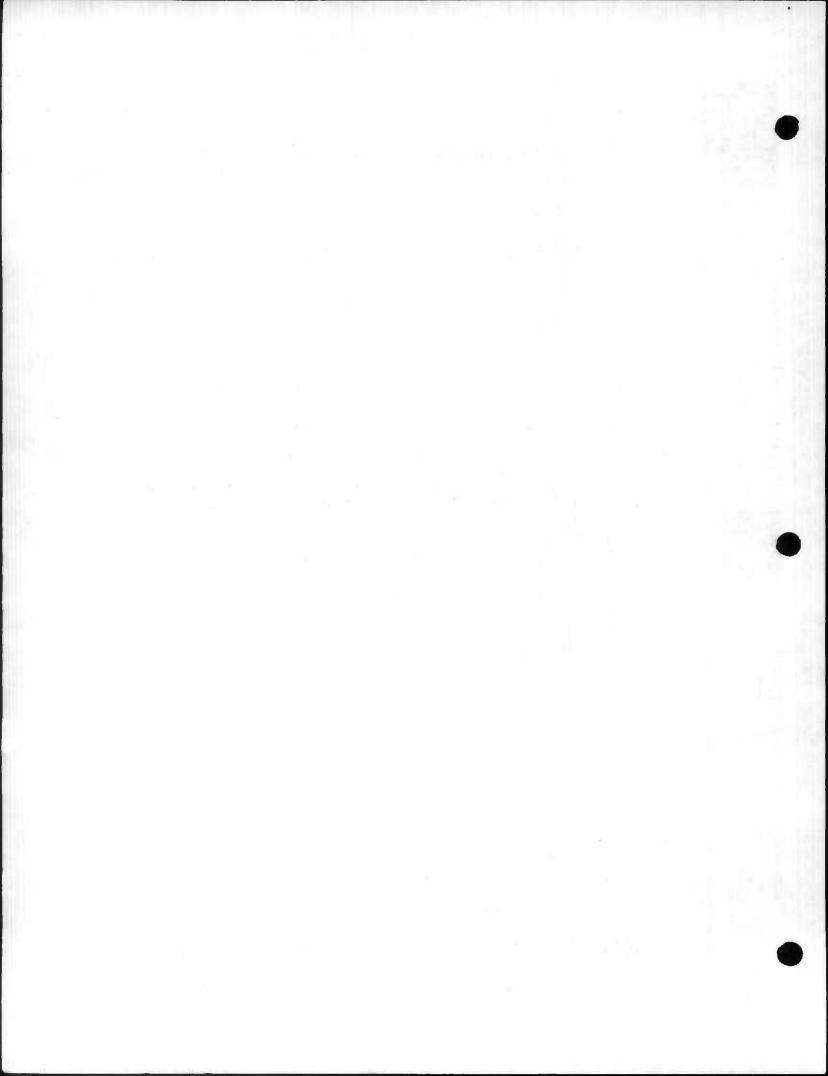
30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** RICHARD LESLIE BRAGG pm JUI /Medical 4a. Facility Name (If not institution, giva street end number 4b. City, Town, or Location of Death 4c. County of Death Examiner City ospital Baltomore Jakyland N/A eneral If Under 24 Hrs. 8. Data of Birth (Month, Day, 05/02/ 7. Aga (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Months 10 M 2□ F 229-12-9251 85 Yrs 1913 Virginia **Director** Usual Rasidance of Decedent the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 25s-f show other traumatic event, the Modical Examinar must be notified at MD N/A BALTIMORE Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 1620 McCULLOH STREET 21217 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Biack, White, etc. 11 Marital Status 1 ☐ Yas 2 No if Yes, Give 1 Navar Married 21 Marriad 1 ☐ Yes 2 ☑ No Black. Specify: þ if Yes, Give Yaar or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast greda complated) 16b. Kind of Business/Industry filed within 7 If Hygiene. Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Laborer s 1 end 2 should be filed w I Heelth end Mental Hygier tem 27 is marked other th 6th 18. Mother's Name (First, Middle, Meiden Sumama) 17. Father's Name (First, Middle, Last) Sonk Albert Mary E. Tisdale 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 end 2 Department of Heelth er Important: If item 27 is any injury or other trai Lee Esther Bragg 1620 McCulloh Street, Balto., MD 21217 20b. Placa of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State Arbutus Memorial Park7/16/98Arbutus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) a of Funeral Service Lice 22. Nama and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD but only one cause on each life.

Do not enter the mode of dying, such as cardiac or raspiratory arrest, and the tonly one cause on each life. Approximate Interval Between Onsel and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting In death) Examiner Examiner bunal-transit certificate be executed Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury pue Due to (or as a consequenca of Box 68760 physician Physician/Medical the that Initiated events resulting in death) Last Due to (or as a consequence of) 80 esn for signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed peen certificate has page 2 2 0 No 1 Yas 2 No 1 ☐ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitai: 1 Yes 2 No Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Aftert Attending 1 Naturai 5 Panding death. 1 ☐ Yes 2 ☐ No investigation Hospital or Attend 24 hours after death Funeral Director: A 2 Accident the 6 ☐ Could not be datamined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 28e. Piaca of Injury - At home, farm, street, factory, offica building, atc. (Specify) N P 4 Homicide 24 hours a edical 29a. Certifier 1 Certifying Physicien: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signature and title of ced 29d. Date signad (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Data of Death **Physician** ALBERTINA B ACKER 1998 JU: Y 04:00AM /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner N/A THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Yaar | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) M1990Uri 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1□ M 20 F 90 Yrs. 007-30-1805 Director Usuai Residence of Decedent with the Maryland 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or itema 23a or 28a-f show the Wedical Examiner must be notified at Yes 2□No Florida N/A Vero Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 吉 600 Riomar Drive 32960 U. S. A. permit. Peges 1 and 2 should be filed within 72 hours after deeth w Department of Health and Mentel Hygiene. Important: if item 27 is married other than "sea profess." Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1□ Yes 2□ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Dance 12 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Albert Rexroth Genevieve Kraus 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Mrs Beverly B. LePage (Dtr) 980 Summit Circle, York, Pennsylvania 17403 20b. Place of Disposition (Neme of cemetary, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Yorktown Crematory 7-15-98 York , Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Fecility Wallace S. Brooks Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** cell cancer of month /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) achy cardin Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiate ceuse. Enter Underlying Cause (Disease or Injury that initiated events iabetes Records, P.O. Box 68%69 Due to (or as a consequence of): resulting in death) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to complation of cause of death? 24a. Was an autopsy performed? Completed s certificate has b 1 Yes 2 No 2000 Division of Vital I or Attending Physician: after death. director, 25. Was case referred to medicel axaminar? Be 26. Place of Death (Check only one) Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) 0 1 Yes 2 No 1 Inpatiant 2 ER/Oulpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Certification: After 1 Natural 5 ☐ Pending 1 Yas 2 No Investigation 2 ☐ Accident Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direcompletely filled in b 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the Vithin 2 29b. Signature and 1966 29c. License number 29d. Date signed (Month, Day, Year) Resident in Otology ngdogs NES-000

31. Date filed (Month, Dey, Year) State Registrar

Robert Ferris

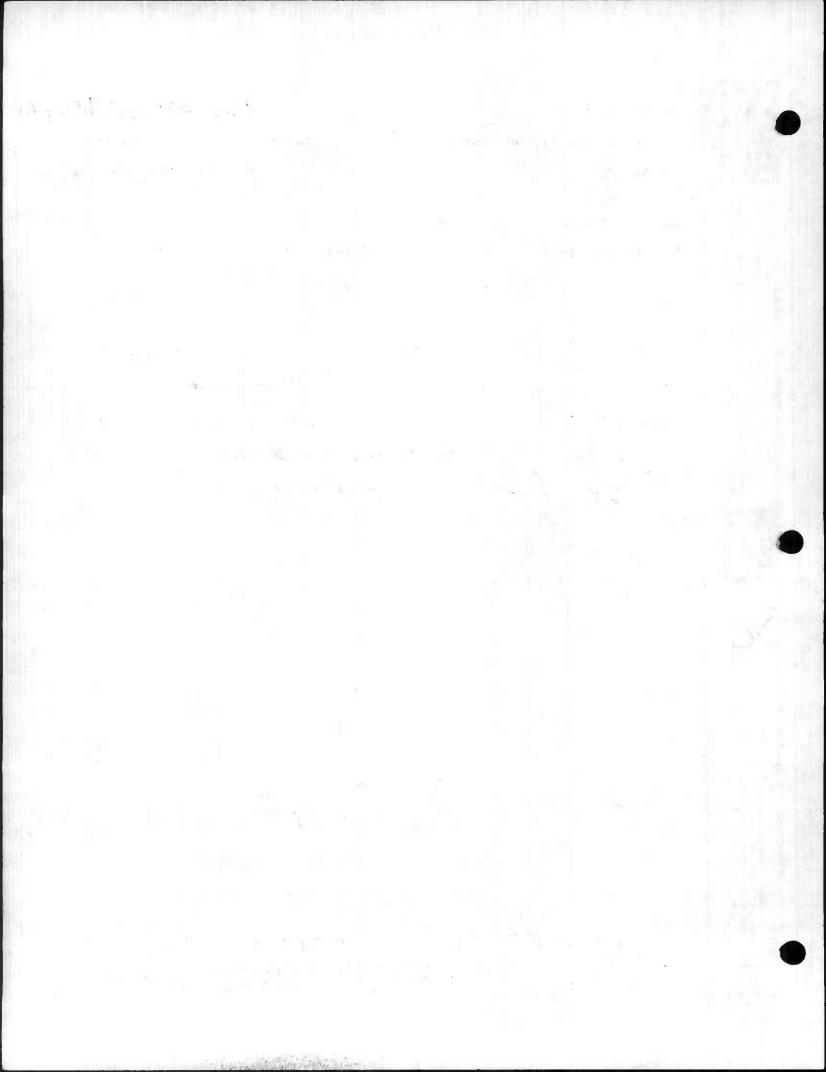
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of person who completed cause of death (Hem 23a) (Type, Print) on thatient center, Floor

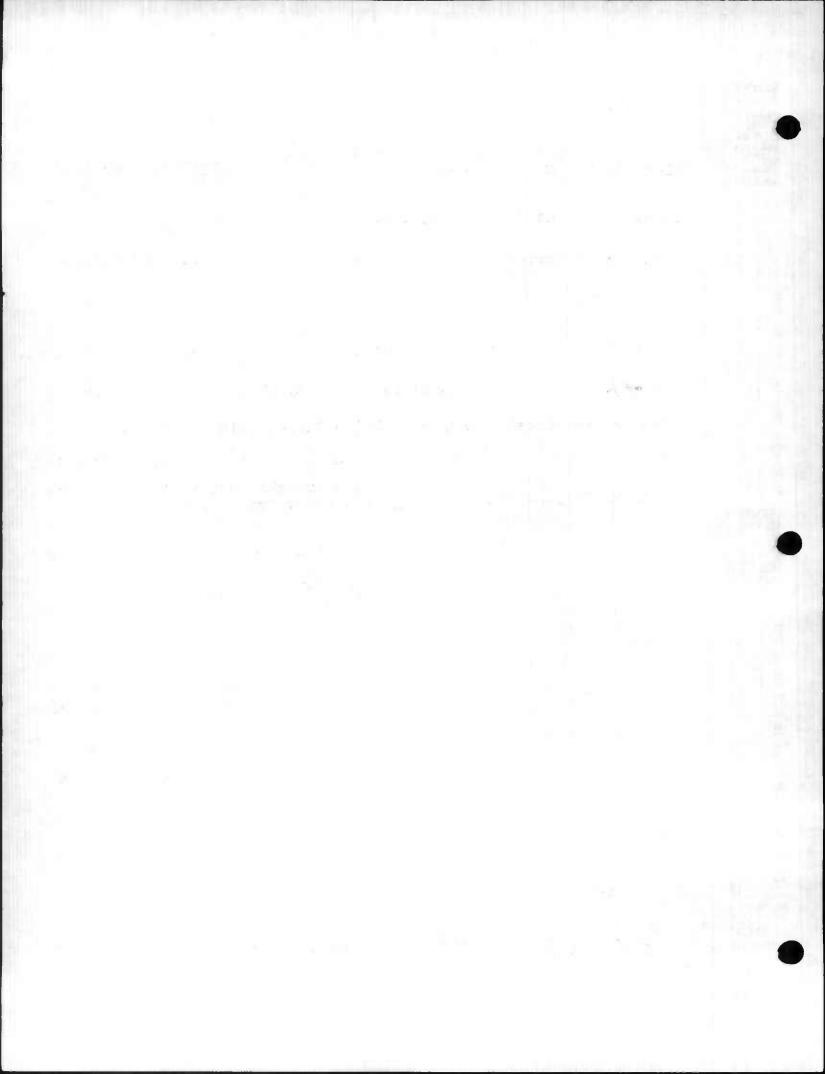
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		1. Decedent's Name (First, I	Middle I	est)				of L		2. Date of D	Reg. No.	40	3. Time of De
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xaminer	ľ	la. Facility Neme (If not insti Mariner Heal						4	Laurel	Location of Dea		nty of Deatl	George
ineral rector	5	5. Social Security Number 164–26–3266		Sex 10 M 2 F		s. last birthday)	If Under 1 Months	1 Year Days	if Under 24 Hr. Hours Mir			9. Birtt	hpiece (State or Fountry) nnsylvani
MOL N		Usuei Residence of Deceder 10a. State 10b. Co			10c. C	ity, Town or Lo	ocation						10d. Inside City L
28a-1 show notified at		MD Cha	arles	3	W	elcome							1 ☐ Yes 2
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Er, or term 23s or 28s-1 shot Examiner multible at Examiner multiple notified at by Funeral Director		11. Marital Status 1 ☐ Never Married 2 ☐ 3 🖾 Widowed 4 ☐ Divo		12. Was Dec Armed Fo 1 Tyes It Yes, Gi Year or D	2 No		Was Decede It Yes, specif		spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)		laca - Amer lack, White city: Whi	
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traumatic TO		19e. Intormant's Name/Rela	tionship (Type, Print)		19b. Maitir	ng Address ((Street a	nd Number or F	Rural Route Numi	ber, City or Tox	vn, State, Z	(ip Code)
other tra		Denise Wilki	insor	1		9045	5 Guns	ton	Road, W	Welcome,	Maryla	nd 20	0693
any injury or other sonce.	2	0a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremal 4 ☐ Donation / ☐ ☐ Oth	tion 3 E	Removal from	0	Place of Dispo	osition (Name	e of her place		Date	20c. Locatio	n - City or 7	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 04 ROZELLA BROWN pm. Julu 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death N/A tinore Cty General 1ary/and HOS 5. Sociei Security Number 7. Age (In yrs. lest yirthday) 9. Birthplace (State or Foreign 1□M aXXF Days 84 PENNSYLVANIA 218-18-1719 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits XYes 2□No MARYLAND BALTIMORE CITY N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 501 W. FRANKLIN STREET 21201-1876 12. Was Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 ÛNo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **TEACHER EDUCATION** 12th grade 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) BELLE MILLARD BROWN unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 4524 Manor View Road, Baltimore, Maryland 21229 Lillian V. Thomas/Stepsister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7-16-98 BALTIMORE, MARYLAND MT. CALVARY CEMETERY neral Service License 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY F/H 1206 W. NORTH AVENUE 23a. Pa 1. Enter the disease, or pomplications that a used the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) theroscleratio Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Mellitus iabetes Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 DUnknown Small Intestinal Obstruction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 28. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Pinpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of

Examiner physician and s the buriel-transit Box 68760 Records, 90

Physician /Medical

> Examiner Physician/Medical Be Completed

certificate has b Certification: To

Physician

/Medical

Examiner

Funeral

Director

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traumatic event, the Medical Examiner must be

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Items 23a

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Director

Funeral

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Completed

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Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I

Medical

State Registrar

28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 BNaturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide 29e. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) and manner as stated 2 Medical Examiner: On the best of my knowledge, deem occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

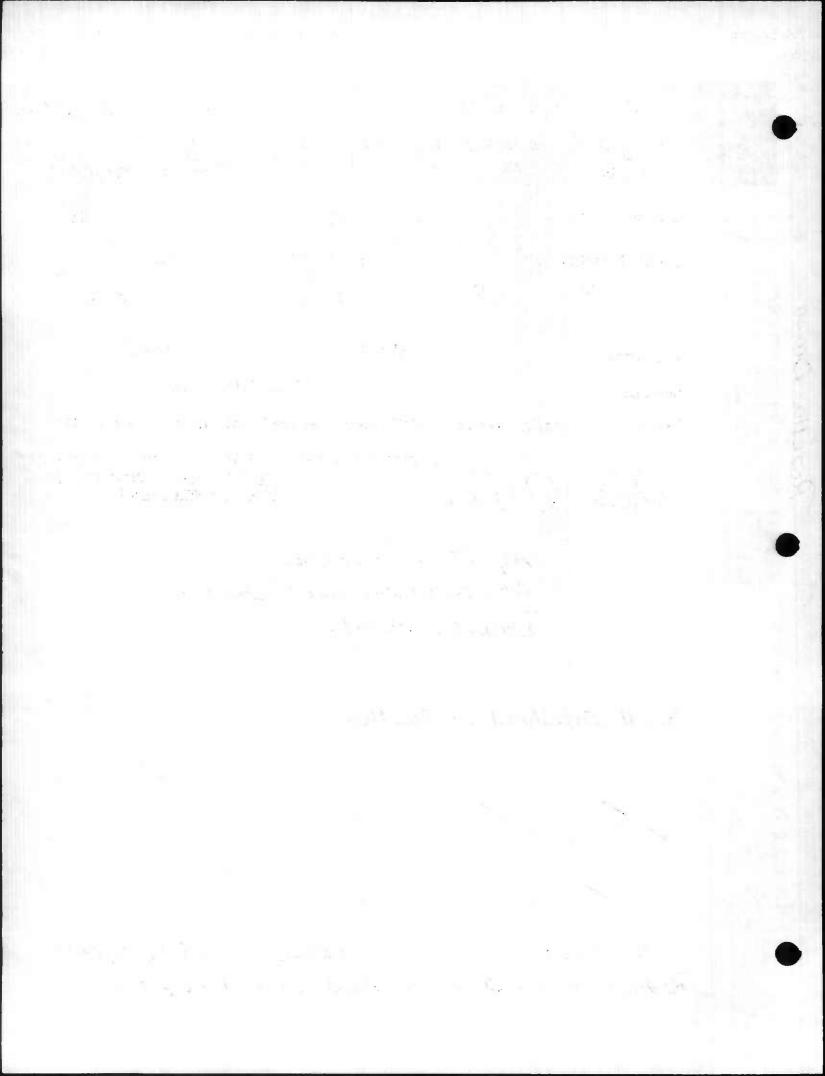
29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of parson who completed ceuse of death (Item 23a) (Type, Print) norad

% Maryland General Hospita MD. 32. Registrar's Signature

31. Date filed (Month, Day, Year) whie Davidson Randall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month MALVINA ELIZABETH CURRERI 1998 5:28 PM JUN 12 4a. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Daeth 4c. County of Daath Fallston General Hospital Fallston Harkord 5. Social Security Number If Under 1 Yaar if Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) Days Hours 1 □ M 2 🛛 F Yrs 213-10-9180 81 Pennsylvania Usuai Rasidance of Decadant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maruland Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 711 Burnside Drive U.S.A. 21015 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indien, Black, Whita, etc. Yas 2 X No f Yas, Give Year or Datas: 1 ☐ Never Married 2 ☐ Married 1 Yas 2 No Specify: 3 ☑ Widowed 4 □ Divorced White 15. Decedant's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th grade Tailor Tailoring 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maidan Sumeme) Joseph Valenti Emilia DiGirolamo 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street end Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Emilia M. Petersam (Daughter) 2305 Carlo Road. Fallston. MD. 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other placa) 20c. Location - City or Town, Stata 1 Buriel 2 □ Cramation 3 □ Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Bel Air Memorial Gardens 7/16/98 Bel Air. Maryland 22. Nama and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21 21. Signatura of Funaral Service Licensaa 21014 23a. Part1. Enter the disease, or complications that can sad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on use him. Approximeta Intarval Betwaan Onset and Death Immediete Causa (Final disaasa or condition resulting in daath) Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury thet Initiated avants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Other eignificant could/lons contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Unknown 24b. Were autopsy findings availabla prior to completion of cause of death? 24e. Wes an autopsy performed? evica 2 1 ☐ Yas 2 ☐ No ~de 4 25. Was casa referred to medical exeminar? 26. Place of Death (Check only one) Hospital: Impatiant 1 Yas 2500 Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 ER/Outpatient 3 DOA

Records, P.O. Box 687 The law requires thet the death cert signed t Division of Vital

Completed by Physician/Medical Be 2 Medical Certification:

29a. Cartifiar

Examiner certificete director, this funeral Aftar

Physician

/Medical

Examiner

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28a-f show

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traumatic event, the Medical Examiner must be notified at

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Depertment of Health er Important: If Item 27 ia any injury or other trau once.

Physician /Medical

Examiner

Pages 1 end 2 should be

Maryland 21215-0020

Baltimore,

or Attending Physician: after death Director: / d in by the f within 24 hours aft To the Funeral Di completaly filled in the Hospital

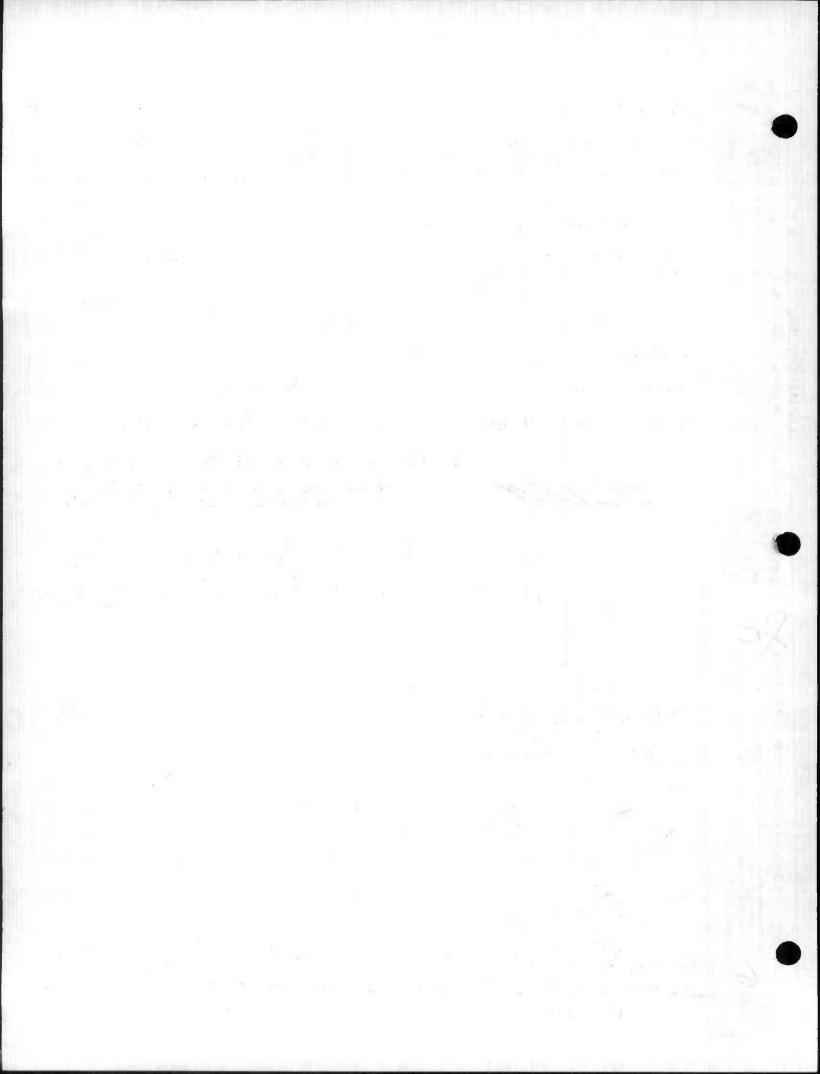
> State Registrar

28a Data of Injury (Month, Day Year) 27. Manufer of Death 28c. Injury at Work? 28d. Dascriba how Injury occurred 28b. Tima of 5 Panding invastigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accidant 6 Couid not be detarmined 3 Suicida Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Steta) 4 Homicide Certifying Physician: To the bast of my knowledge, deeth occurred at tha tima, data and place, and due to the causa(s) and mennar as stated. (Check only one) miner: On the basis of exemination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29b. Signaturé 29c. Licensa number 29d. Date signed (Month, Day, Year,

o completed causa of death (Itam 23a) (Type, Print)

1308 Business CAN ,00

32. Ragistrer's Signatura whice Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedant's Nama (First, Middla, Last) 2 Date of Deeth Year Month 23:5 Care Lee ILCL Shirley 1998 4bnCity, Town, or Location of Deeth 4e Facility Nama (If not Institution, give street and number) 4c. County of Death altimore Hopkins Johns HOSPITA If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 7. Aga (In yrs. last birthday) 6. Sex Birthplaca (Stata or Foreign Country) Montha Days 1 M 2 F 63 Yrs 27, 1935 MARYLAND 215-30-6024 Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County 1 ☐ Yas 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1214 ASTER DRIVE 21061-2917 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indian, Black, Whita, atc. 11. Marital Status 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No If Yas, GiveX 1 Yas 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER 12 OWN HOME N/A 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surnama) ROBERT ROGERS MINNIE VIOLA THICKER 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code, 19a. Informant's Name/Ralationship (Type, Print) I. CAREY (HUSBAND) 1214 ASTER DRIVE, GLEN BURNIE, MD. 21061-2917 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Ramoval from State GLEN HAVEN MEMORIAL PARK 7/13/98 GLEN BURNIE, MD. 4 Donation 5 Other (Specify) 22. Name end Address of Feellity SINGLETON FUNERAL HOME, PA, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 be complications that ceused the deeth. Do not antar tha moda of dying, such as cerdiac or respiratory arrast, List only one cause on each line. 23a. Part1. Enter the dishock, or heart and Approximata totarvel Batween Onset end Deeth Immediata Ceusa (Final disease or condition resulting in death) myocardial hours Due to (or as a consequence of): COronary years Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Dua to (or as a consaquanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 No 25. Was casa rafarred to medical 26. Placa of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Stripatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how Injury occurred

1 Tyes 2 No

RES-000

Baltimore,

1 😿 Certifying Physician: To tha bast of my knowledga, deeth occurred et the time, dete and placa, and dua to tha causa(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated.

29c. Licansa number

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

MD 21287

Physician /Medical Examiner

Physician

/Medical

Examine

Funeral

Director

r 28a-f show incitified at

r than "natural", or items 23s or the Medical Examiner must be r

permit. Pages 1 and 2 should be filed within 72 hours after death. Depertment of Health and Mentel Hygiene.

. Health (

Important: If It any Injury or o

Baltimore, Maryland 21215-0020

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Funeral

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Examine physician and the burief-transit Physician/Medical US9 should b Completed has Be

P.O. Box 68760.

Division of Vital Records,

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Certification:

The law requires that the death certificate be asscuted or Attending Physician: after death. Director: Aft filled in • Funeral Hospital To the Hosp within 24 hor To the Fune completely fi

31. Data filed (Month, Day, Year) 151998

29b. Signatura and titla of certifian

Kop

1 Netural

2 Accident

3 Suicida

29a. Certifiai

4 Homicide

(Check only one)

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5 Panding invastigation

6 Could not be determined

600 32, Registrar's Signetura was Davidson-Randall

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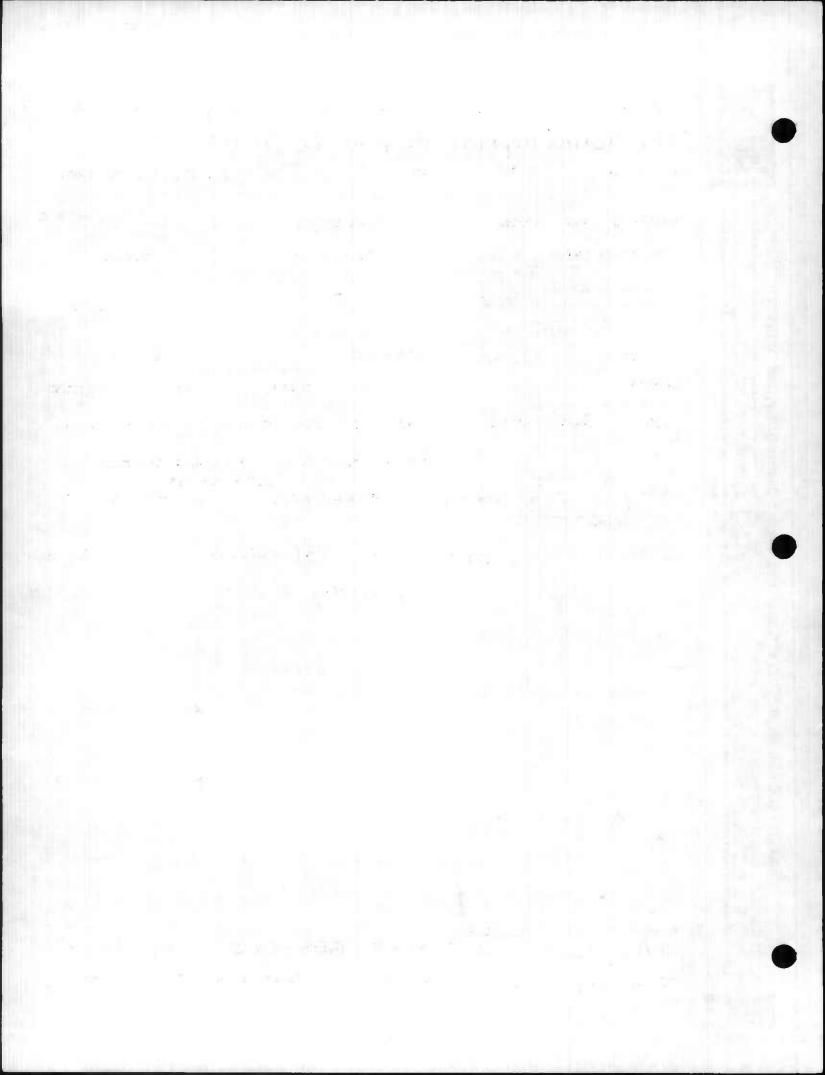
30. Name and eddress of person who complated causa of daath (Item 23a) (Type_Print)

Plece of Injury - At home, farm, streat, factory, office building, atc. (Specify)

resident

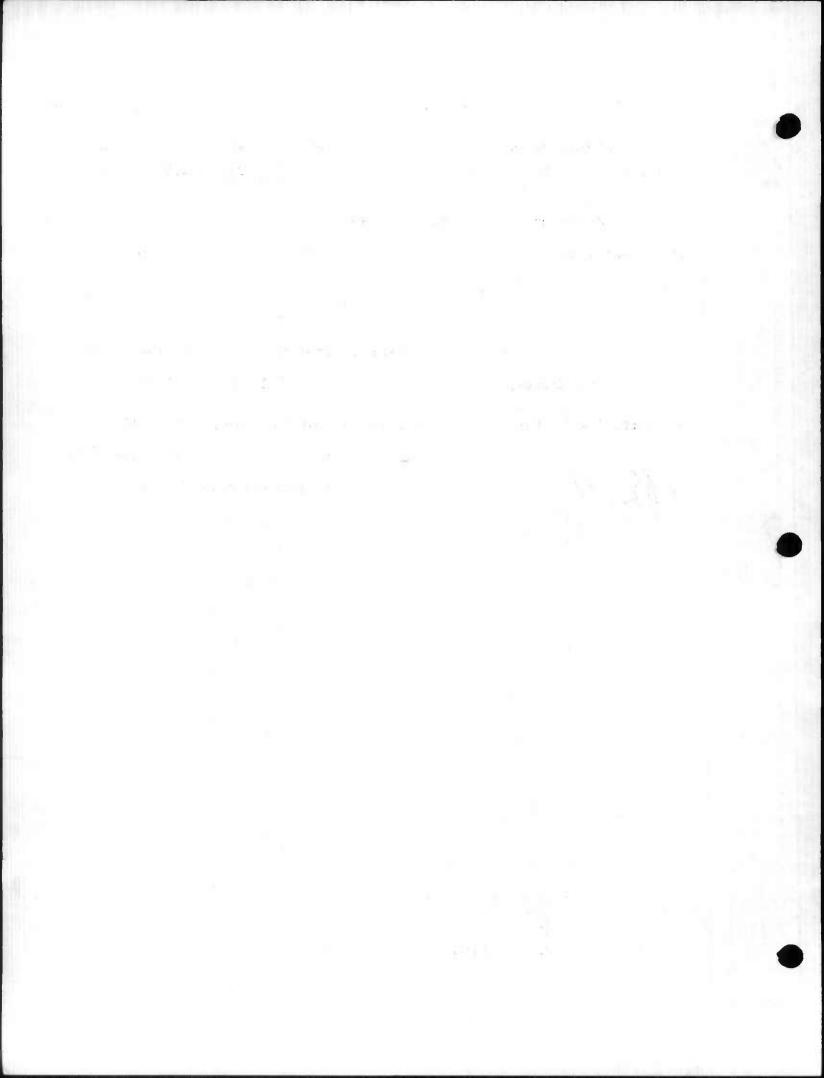
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State Registrar



State of Maryland / Department of Health and Mental Hygiene

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	Examii	ner	4e. Fecility Neme (If	not institution, giv	e street end number))			4b. City, Town, o	r Location of Deel	h 4c. C	County of Deeth	ľ	
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	P ***		Usuei Residenca ot i 10a. Stete	10b. County		10c. City, To	wn or Loc	ation	-				10d. Inside City I	Limits
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	with the Mary 3e or 28a-f shu it be notified a	I Director	10e. Street end Num 1623 Gibb					10f. Zip Coo	21777		10g. Citize	en of What Cou	intry?	
020	within 72 hours after death with the Marylar no. than "natural", or items 23s or 28s-f show he Medical Examiner must be notified at	by Funeral	11. Maritel Stetus 1 Never Merrie 3 Widowed 4		12. Wes Decedent Armed Forces? 1 Yes 2 H If Yes, Give Year or Dates:		It	Ves Decedent Yes, specify (of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or Norto Rican, etc.)		I. Rece - Amer Black, White Specify: WF		
20	n 72 hours "neturn!", edical Exa	eted		15. Decedent's Ed y only highest gre		18	e. Deced	ent's Usuel Oc	cupation	orkina	16b. Kind	d of Business/I	ndustry	
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lary	~ 5 5	-	19e. Intorment's Ner	me/Relationship (Type, Print)	19	9b. Meilin	g Addrass (St	reet and Number or F	Rural Route Numb	er, City or	Town, State, Z	ip Code)	
	and 2 selft a n 27 is ser tra		Nicolette	Jeanine	Carnes	I	2.0.	Box 15	9 Point o	f Rocks,	MD	21777		
Baltimore,	permit. Pages 1 and 2 Department of Health I Important: If Item 27 is eny Injury or other tra ence.				Removei from Stete	ceme	ery, crem	etory or other ort Cem	pleca)	7/10/98		ation - City or T exandri		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Nicholas Jona than July 1998 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number, 4c. County of Deeth Baltimore City If Undar 24 Hrs. 8. Data of Birt Union Memorial Hospital N/A If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 1X M 2□ F Days 2 Hours Min. Yrs N/A Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland Baltimore City N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3921 Rexmere-Road 21218 United States 12. Wes Decedent Ever in U,S Armed Forces? 14. Raca - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 ☐ Yes 2 🗷 No If Yes, Give Yaer or Detes: 1 X Never Merried 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Not Self Supporting Elementary/Secondary (0-12) College (1-4or 5+) 0 Dependent 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Unknown Nichole R. Carter 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3921 Rexmere Road Baltimore, MD 21218 Nichole R. Carter / Mother 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 X Burial 2 ☐ Crametion 3 ☐ Removel from State Dulaney Valley Memorial Gardens 7/17/98 Timonium, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Addrass of Facility Timothy Harman Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart felicle. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Extreme Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying Ceuse (Disease or Injury that initiated events 10.6 Dua to (or as a consequence of) rasulting in deeth) Last Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 [X] Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? 5 Pending Investigation 1 Natural 1 Tyes 2 No 2 Accident

35 **esn** Division of Vital Records, paga 2 After this certificate has funeral To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Madical Examiner must be notified at

ŏ permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiena. Int: If Itam 27 Is marked other than "natural", or Ita

altimore, Maryland 21215-0020

with the Maryland

death

Physician/Medicai À Completed Be 2 Certification:

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25. Wes case referred to medical examiner? 1 ☐ Yes 2 No

4 Homicide

(Check only one)

29e. Certifier

6 Could not be 3 Suicida

28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier

29c. Licanse number

Memoria

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

31. Dete filed (Month, Gan Year) 5 1998 32. Registra s Signature

State Registrar

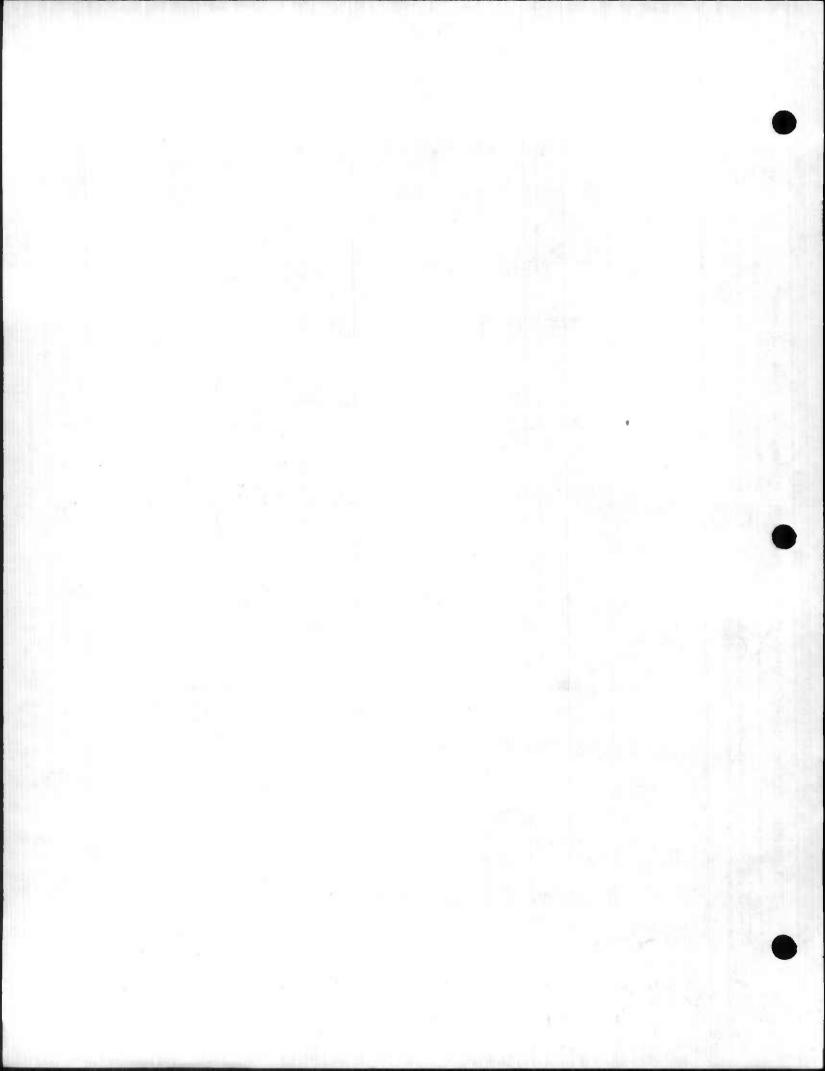
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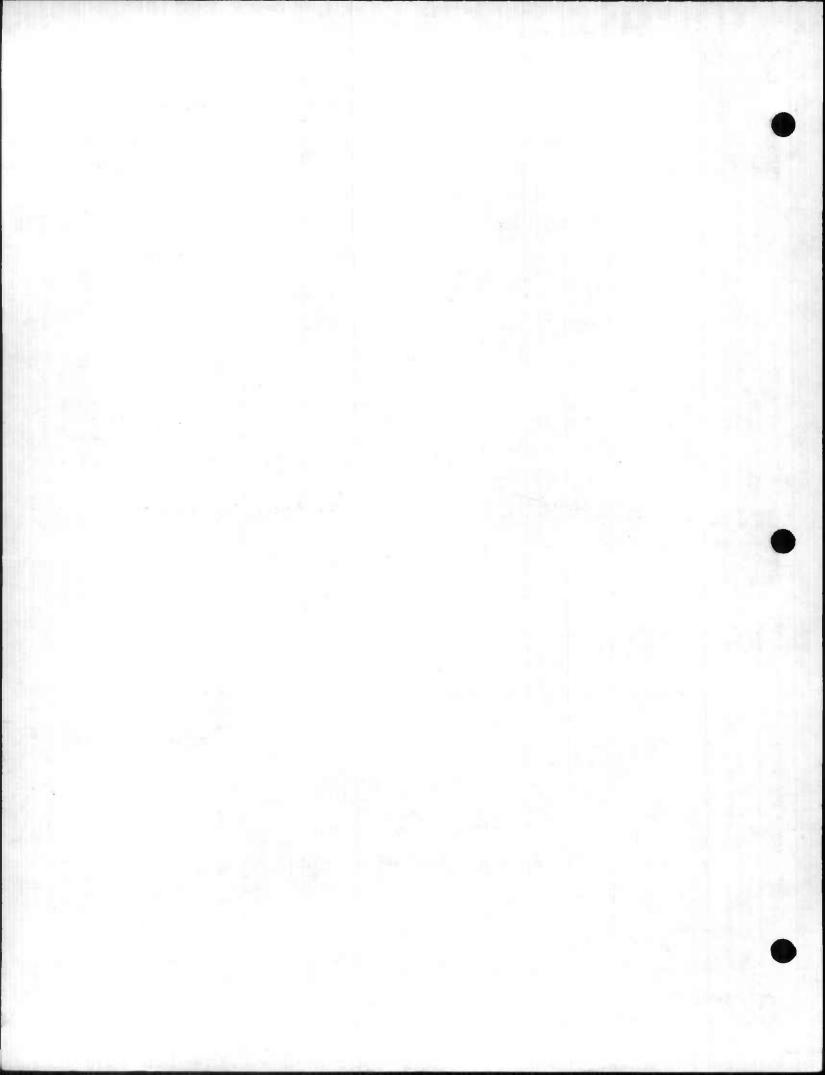
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ian	1. Decedent's Name (First, Middle, La.	st)		te of D		2. Date of Deat Month	h Day	year 3. T	ime of Death
cal -	MARIE S.	DUBACK							:20 PM
ner	4a Facility Name (If not institution, give				. City, Town, or Lo		4c. County	of Death	
	CANTON NURSING HOL		William William		ALTIMORE				
	5. Social Security Number 218-26-2714 Usual Residence of Decedent	OM 200 F 7. Age (In yrs. In	Yrs. If Ono Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, DEC. 21,		9. Birthplace (Country) MARYLA	
1-	10a. State 10b. County	10c. City,	Town or Location					10d. In:	side City Limits
to	MARYLAND	BAL	TIMORE CI	TV				X	Yas 2 No
Directo	10e. Street and Number			ip Code		1	0g. Citizen of V	What Country?	
i	910 SOUTH KENWOOD			2122			USA		
	11. Marital Status 1 Never Married 2 Married 3(2)Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			panic Origin? (Spo , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Ind ck, White, etc. v: WHIT	
ľ	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Decedent's Us	ual Occupat	ion Irina most of work	ina	16b. Kind of Bu	usiness/Industry	
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1	8TH 17. Father's Name (First, Middle, Last)		CUSTODI	-	18. Mother's Name	First Middle 4	CHURCH		
	HENRY ANDREW PUS					RY FUCHS	naloen Suman)	
F	19a. Informant's Name/Relationship (19b. Mailing Addre	ss (Street ar			City or Town	State. Zio Code)
-	EDWARD F. PUSKAR		3512 EAS						
ŀ	20a. Method of Disposition	20b. Pla	ace of Disposition (Nametery, crematory or	ame of		Date	20c. Location -	City or Town, Si	ata
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1	21. Signature of Funeral Service Licen		22. Name	and Address	of Facility			KE CITY	
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	23a. Part1. Enter the disease, or com	plications that caused the death.	Do not enter the mo	ode of dying,	such as cardiac	Or respiratory arri	MAKYLA	NU 2121 Appr	3 oximata
	shock, or heart failure. List only	One cause on each wie.							ral Between t and Death
	Immediate Cause (Final disease or condition	PNU	mania					2	0441
ı	resulting in death)	Due to (or	as a consequence of):					1'
		B- ALTHE	inc	DE	MEAY	8		1 41	4
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of):					
	cause. Enter Underlying Cause (Disease or injury that initiated events	с.						i	
	resulting in death) Last	Due to (or a	as a consequence of):					
		d							
	Part II. Other significant conditions of	ontributing to death but not result	ting in the underlying	cause giver	n in Part I	23b. Did to	bacco use co	ntribute to the c	ause of death
1	The state of the s	The state of the s					98 2□No	3 Probably	Contract of the Contract of th
	Mymo SC	Carl VAIU	man Will	44.11					/
	TUDS IT	DASKE M	cellt-			24a. Was a perform	n autopsy ned?	24b. Were au available	prior to
	14-2	181 A MILES						of death	on of cause
						1 🗆 Ye	s 2000	1 ☐ Yes	2 No
					26. Place of Deat	-			
	25. Was case referred to medical examiner?				r V			er (Specify)	
	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E			4 LANursing Ho	me 5 Reside			
	examiner? 1 Yes 2 No 27. Manner of Death 1 Notural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury	at 7	me 5 Reside 28d. Describe ho			
	examiner? 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury a Work? 1 Ye	at 7 es 2 No	28d. Describe ho	w injury occur	red	a Number
	examiner? 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury a Work? 1 Ye	at 7 es 2 No	28d. Describe ho	reet and Numb	per or Rural Rou	
	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hon building, etc. (Specify) yelclan: To the best of my know theer: On the basis of examination	28b. Time of Injury M ne, farm, street, factor	28c. Injury a Work? 1 Yeary, office	at 7 es 2 No	28d. Describe ho	reet and Numb n, State)	per or Rural Rous	-
	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hom building, etc. (Specify)	28b. Time of Injury M ne, farm, street, factor ledge, death occurre on and/or investigation	28c. Injury a Work? 1 Yeary, office	es 2 No	28d. Describe ho 28f. Location (Si City or Towr and due to the ca ed at the time, di	reet and Numb b, State) ause(s) and mate and place,	per or Rural Rous	ause(s)
	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hon building, etc. (Specify) yelclan: To the best of my know theer: On the basis of examination	28b. Time of Injury M ne, farm, street, factor ledge, death occurre on and/or investigation	28c. Injury 2 Work? 1 Your 2 Ory, office d at the time on, in my opi	es 2 No	28d. Describe ho 28f. Location (Si City or Towr and due to the ca ed at the time, di	reet and Numb b, State) ause(s) and mate and place,	per or Rural Rous	ause(s)
Medical Certification: 10 B	examiner? 1	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At hon building, etc. (Specify) yelclan: To the best of my know there: On the basis of examination and manner stated.	28b. Time of Injury M ne, farm, street, factor ledge, death occurre on and/or investigation	28c. Injury 2 Work? 1 Your 2 Ory, office d at the time on, in my opi	es 2 No	28d. Describe ho 28f. Location (Si City or Towr and due to the ca ed at the time, di	reet and Numb b, State) ause(s) and mate and place,	per or Rural Rous	ause(s)



State of Maryland / Department of Health and Mental Hygiene

					Cen	tificate	of I	Death			Reg. No.	3 6	1010
		1. Decedent's Name (First, Middle, L	ast)		110	Model				2. Date of De		Van	3. Tima of Death
Physic		Puriben Ravji	Dalsania							July 1	Day 1998	Year	11:45 a.m.
/Medi Exami		4a Facility Name (If not institution, g					14	b. City, Tov	wn, or Lo	cation of Death	-	of Death	
Exam.		13517 Gresham (Court					Bowi	e		Prin	nce G	eorge
Funeral		Social Security Number 6.		e (In yrs. last bi	irthday)	If Under 1		If Under 2	24 Hrs.	8. Dete of Birt	h		lace (State or Foreign try)
Director		589-68-2563 Usual Residence of Decedent	1□M 2\(\text{\text{\$\exititt{\$\text{\$\exititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}	82	Yrs.	Months (Days	Hours	Min.	(Month, Day, Year) Jan. 1, 1916 India			
dand dand		10a. State 10b. County	nty 10c. City, Town or Location							10	Od. Inside City Limits		
the Mary 28s-f eh	ector	MD Prince	George	Bowi	.e	10f. Zio Ci	ada				10a Chinas al l	Affrat Cours	1 ☐ Yes 2 🔯 No
death with the Maryland rms 23e or 28e-f show	Funeral Director	13517 Gresham (7	ourt 2072			20				10g. Citizen of What Country? India		
urs effect Mr. or the Lamba by Fu		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Wes Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Datas:	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto		jin? (Spi , Puerto			Rece - American Indian, Bleck, White, etc. Poilly: Asian		
21215-0020 Within 72 hours of gions: The man "natural, or	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a	. Decede	ent's Usuat C	Occupa done d	ation durina most	of work	ina	16b. Kind of Bu	usiness/Ind	lustry
N = 5	hope	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. D	O NOT use	retired	1)					
N Page 1	Co	Ø	Ø		Home	maker		THE PERSON NAMED IN			Own Ho		
STEP STEP STEP STEP STEP STEP STEP STEP	Be	17. Father's Name (First, Middle, Las									Maiden Surnam	70)	
Men Men	2	Ravjibhai Buta								lable)			
Maryland d 2 should be file in and Mental Hy file marked othe traumatic event.		19a. Informant's Name/Reletionship									er, City or Town,		
per man day an	1/	Pravin Dalsania	a/Grandson					n Cour	τ, 1		Maryland		
0 #552		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	Removal from State	20b. Place 0 cemets	of Dispos kry, crem	atory or othe	or or plac	oe)	1	Date	20c. Location -	City or To	wn, Stete
Baltim permit. Pag Department important: I any injury o		4 □ Donation 5 □ Other (Spec	Wy)	Balti	more	Wash	ing	gton C	r	7/11/98	Laure	el, M	aryland
Balt permit. Departiment import any inj		21 Signature of Funeral Service Lion	original			Name and A							
m 89758		1 5	19		1	leck	Fur	eral	Home	, Inc.			
		23a. Part1. Enter her disselse, or con shock, or heart larters. List on	holications that caused	the death. Do	not ente	the mode o	and of dyin	g, such as	andiac o	r respiratory a	rest.	Mary.	Approximate
Physician		SINGS OF HEART SAME. LIST ON	y one cause on each ar				1)				1	Onset and Death
/Medical	Н	Immediate Cause (Final disease or condition	/ Ac	01-1			11/	/					
Examiner		resulting in death)	. '15	Due to (or as a	COURAGE	mance off:	V	DEU	200	Ma		-	
	ě		3	open to (or as a	purisingu	merico org.						- 1	
De 75	Examine	Commentally list conditions	b	Due to (or as a	consequ	ence off:	-					-	
500	Exe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		DOG TO STATE OF	childeda	the same dust.						- 1	
8 X	edical	that initiated events	6.	Due to (or as a	consonu	noon off-						-	
0	Pe	resulting in death) Last		one to for as a	consequ	and orp.							
XO ugu	3		l d									-	
0 5 4 5 O	흥	Part II. Other significant conditions	contribution to double by	d and annulling i	in the con	destrine en		on in Start I		20h Did	lohaceo una co	ntelbude to	the cause of death 5
0 2 5 6	Physician/	Part II. Other significant conditions	contributing to death bu	it not resulting i	in the un	derlying caus	se gw	wei in Part i.			and the same		the cause of death?
프 본 정칭	y P									10	766 203 760	all From	and all ournoun
De de la la la la la la la la la la la la la	Be Completed by									24a. Was perfo	an autopsy med?	BVI	ore autopsy findings ulable prior to repletion of cause death?
The law ate has page 2 a	Ĕ									. 171	/as 219 No		Yes zhi No
	O	25. Was case referred to medical					-	no file	-10-11				Tree statue
		examiner?	Hospital:	aClenio.		aC 004	Oth	er:		h (Check only o	-0.77	or Person	A .
Phys of	. To	1 ☐ Yes ZIQ No 27. Manner of Death	28a. Date of Injur	nt 2 ERVO	Time of	1000	Inion				tence 6 DOth now injury occur		9
A Share	tlon	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	м	Worl	k? Yes 2□N		2540/24/46/11/10	TOTAL PROPERTY.		
VISION Attending r death. ector: Alte by the lune	Ica	3 Suicide 6 Gould not	be one place of take	ov - At home, fa	tem eten					28f Location /	Street and Numt	wer or Rura	f Route Number.
m 8255	Certification:	4 ☐ Homicide determine	building, etc	(Specify)		di, incidi y, o	annua .			City or Tox	vri, State)		Transfer of the state of the st
al series	ő	29a. Certifier 1M Certifying P	husieles: To the best o	i mu knowlodou	o doeth	annumed at	the tim	no data and	d plane	and due to the	seuso(s) and m	n n n n n n n	alod
To the Hospital within 24 hours To the Funeral completely filled	edical		hysician: To the best o miner: On the basis of and manner sta	examination an	nd/or inve	estigation, in	my o	pinion, deat	h occurr	ed et the time,	date and place,	and due to	the cause(s)
thin o the	M.	29b. Signature and title of certifier				29c. L	icens	e number			29d. Date signe	d (Month.	Day, Year)
F≯Fŏ		100 A	08	Sigh	M		T		66		7-	13-	0.0
7		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, P	Print)	1	ANO		\$ 1	. 1214	F	OCIE ME
7_		21 200 (100 (100 11)	TILL AN	ado:	+0		-	7,00		Ju	D 15 4)	0_	28316
Sta Registi		31. Date filed (Month, Day, Year)	32 Hedistra	Signature Davidson—	Aanda	200							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey 14 L Month WILLIAM JOSEP H ERNST 1998 7014 08=2644 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth HAZFOR FALLSTON FALLSTON 2 cm -HOJPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | Dec. 21 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign Country) 1**X** M 2□ F 88 213-10-7308 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3 Stoneleigh Place 21014 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ½ Yes 2 □ No If Yes, Give Yeer or Detes: 1944-45 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 8th grade (0-12) Coilege (1-4or 5+) Insurance Adjuster Insurance 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Henry J. Ernst Mary Blotkamp 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Dolores R. Wolf (Daughter) 3 Stoneleigh Place. Bel Air. MD. 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 Buriai 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith Cem. 7/17/98 Baltimore, Maryland 22. Name end Address of Fecility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21 21. Signeture of Funeral Service Licenses Buian a 21014 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. tmmediete Cause (Finel disease or condition resulting in deeth) ASOUD Due to (or es a consequence of) Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Box 68769

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

by

Completed

Be

traumatic event, the Medical Examiner must be notified at

the Maryland

permit. Peges 1 and 2 should be filed within 72 hours after death with it Department of Health end Mental Hygiene. Important: if frem 27 is marked other train "natural". ~ 1000s.

Examiner Physician/Medical ate has been signed by page 2 should be detect this certificate

The law requires that the death certific Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, in by the

To the Hospital or within 24 hours aft To the Funers! Di completely filled in

State Registrar

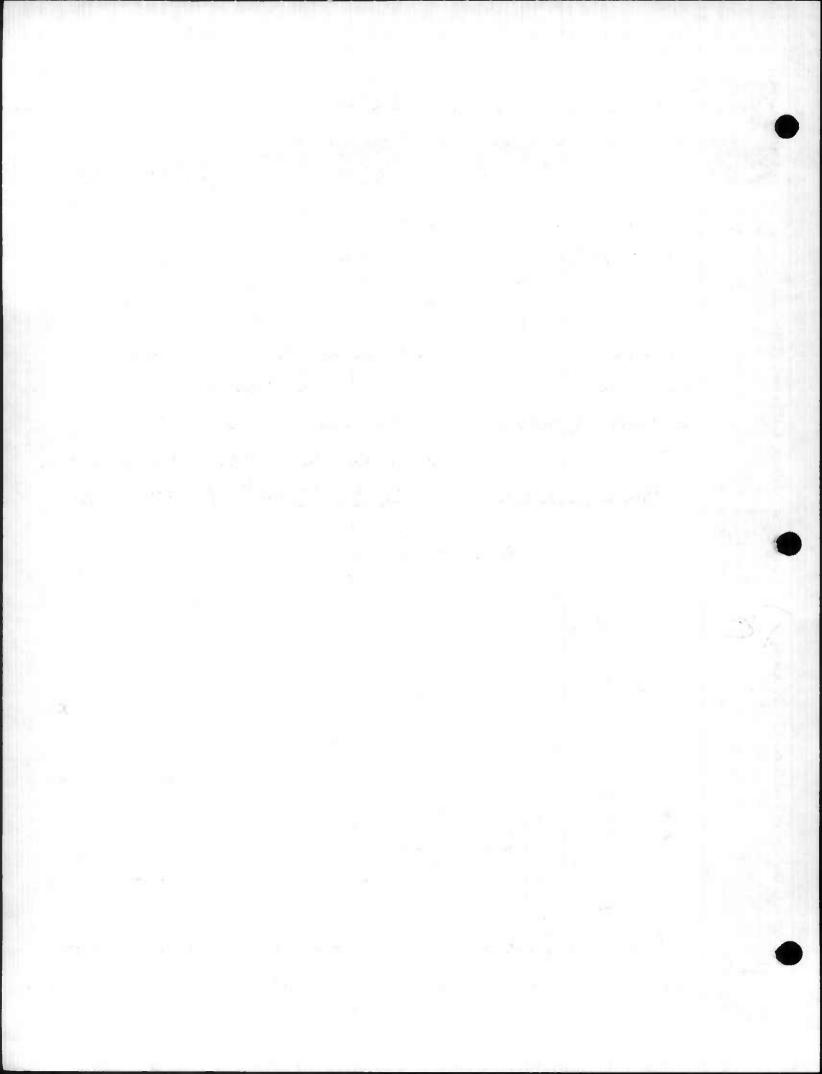
Pert it. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. þ Completed 25. Wes cese referred to medicel exeminer? Be 1 Yes 2 No Certification: To 28e. Dete of Injury (Month, Dey Year) 28b. Time of injury 27. Menner of Deeth 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☑ No investigation 2 Accident NA NA NA 6 Could not be determined 3 Suicide 28e. Plece of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature end title of certifier 29c. License number

29d. Dete signed (Month, Dev. Year)

DME 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

FULFORD SHE M.D 218 BEZAIR MD 21014 874-6564

32. Registral s signature



	ENCE F. E	EVANS, SR.		C	ertificate o	f Death	R	leg. No.	8 2	1680
		1. Decedent's Neme (First, Middle, L	ast)				2. Date of Dee	th		3. Tima of Deeth
	Physician /Medical	LAWRENCE	F. EVAN	SSR			JULY 1	Day 1. 1998	Year	0715AM
1	Examiner	4a Fecility Neme (If not institution, g				4b. City, Town, or	Location of Death	4c. County		0 / 2 0 1 2 1
		6817 HUNTINGTON	DRIVE			BALTIMOR	RE	BALTI	MORE	COUNTY
	Funeral	Social Security Number 6.	Sex 7. Age (In)	rs. last birthda	y) If Under 1 Ye Months Day	er If Under 24 Hrs	6. Date of Birth (Month, Day	1	9. Birthole	ace (State or Foreign
	Director	426-38-8667	18 4 2 F 66	Yrs.			JUNE 8	, 193	2MISS	5
	s 1 and 2 should be filed within 72 hours after death with the Maryland filed the and Mental Hygiene. The stranged other than "natural", or itema 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	Usual Residence of Decedent 10e. Stete 10b. County NJ MT .	HOLLY 10c.	City, Town or	Location	N/A			10	d. Inside City Limits
	Serie Me									1 Yes 2 No
	vith the Mar	10e. Street and Number			10f. Zip Code		1	Og. Citizen of V		ry?
	23 v	25 KANABE C				08060		U.S.A		
•	r item 23s	11. Meritel Status	12. Wes Decedent Ever in Armed Forces?	n U,S. 13	I. Wes Decedent of If Yes, specify C	of Hispenic Origin? (5 uban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		e - America ck, White, e	
50	y F	1 Never Married 2 Married 3 Widowed 4 Divorced	N Yes 2 No 1 If Yes, Give Yeer or Dates: 1	952	1 Yes 200	lo Specify:		Specify	BLAC	CK
21215-0020	be filed within 72 hours at the hygiene. If dother than "natural", of event, the Moder Exp. Be Completed by	15. Decadent's			edent's Usuel Occ	cupation		16b. Kind of Br	isinges/Indi	uetny
5	in 72 in 72	(Specify only highest g	rade completed)	(Giv	e kind of work do	ne during most of wo	orking	Too. King of Bi	231103311101	ustry
212	om than o	Elementary/Secondary (0-12)	College (1-4or 5+)	COLIN	ISELOR			ST OF	NJ	
0	Hyg ether	17. Father's Name (First, Middle, Las		10001	OLDON	18. Mother's Na	me (First, Middle, I			
a l	Mentai arked o atic eve	WILLIE EVANS				MAR	THA CHA	TMAN		
· 20	2 should end Men is marke aumatic	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Stre	et and Number or R		The state of the s	State, Zip	Code)
	1 end 2 Health e em 27 is ther trau	LAWRENCE EVAN	S JR/SON	6817	HUNTI	NGTON DR	BALTO	, MD	21207	7
o .	00-5	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State	cametery, cr	position (Name of ematory or other p / ET MEM	olace)	Date 7-17-98	20c. Location -		
	5 6 3	21. Signature of Funeral Service Lic	**		22. Name end Ad	dress of Fecility	ETTS FU	NERAL	HOME	2
ä	Departi Departi Import any inj pnce.	Iloh no	1 Most	1	l129 N.	CAROLIN	E ST BA			
		23a. Part1. Enter the disease, or co shock, or heart failure. List only	mplications that caused the d	eath. Do not e	nter the mode of o	tying, such as cardie	c or respiratory arr	est,		Approximate
	Physician	shock, or heart failure. List on	y one cause on each line.							Intervel Between Onset and Death
	/Medical	Immediate Cause (Final	Ambania 1		0	1 Di			1	
E	Examiner	disease or condition resulting in death)	e Arterioscl	o (or es e cons		ascular Di	Lsease			
	je L		Due	0 (01 63 6 00113	aquance on.				1	
	Examiner	Sequentially list conditions	b	o (or as a cons	equenca of):					
16		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury								
8	ica ica	that Initiated events resulting in death) Last	C. Due to	o (or es a cons	equence of):					
9	oding pt	resolving in coalin) cast								
Вох	ettending phe ettending phe difor use as it		d							
0	0 0 6 60	Part II. Other eignificant conditions	contributing to death but not	resulting In the	underlying cause	given In Part I.	23b. Did to	obacco uae co	ntribute to	the cause of death?
д	d by t etach	Diabetes Mellit	110				101	es 2 No	3 Prob	ably 40 Unknow
Ś.	bed yd	_ Diabetes Metilit	us						1	
ecords,	the law require sate has been single 2 should I completed						24a. Was a perfor	an autopsy med?	ava	re autopsy findings ilable prior to
9	hes by						INSPE	CTION	of d	npletion of cause leath?
E ;	Son Pege							es 2 No	10	Yes 2□ No
Vita	Physician: The la this certificate her ral director, pege 2	25. Wes case referred to medical examiner?					ath (Check only or	ne)		
0	this ce al dire	1 Yes 2 No	Hospital:	ER/Outpati	ent 3L DUA		Home 5 Resid	enca 6 XOth	er (Specify	AT SCENE
	ng Ph fter th neral	27. Manner of Death 1 Naturel 5 Pending	28e. Date of Injury (Month, Day Year	28b. Time Injury		njury at Vork?	28d. Describe h	ow Injury occur	red	
Sio	Attending or deeth. ector: Afte by the fune tification	2 ☐ Accident investigati			M 1	Yes 2 No				
-	T T	3 Suicide 6 Could not 4 Homicide determine		it home, farm, s ecify)	street, factory, office	ca	28f. Location (S City or Tow		per or Hural	Houre Number,
	ours e	No Contract of Contract	hustoles . W. d. L		-th	41				at and
-	n 24 hound no 24 h		thyaician: To the best of my miner: On the basis of examend manner stated.							
4	within 24 hours of within 24 hours of completely filled in Medical Cel	29b. Signature and life of certifier	diomainer stated.		29c. Lice	ense number	1 2	29d. Dete signe	d (Month, E	Day, Year)
F	- \$ 1 0	VA.	in the MIN	\		CME		.TIT.V 1	1 10	000

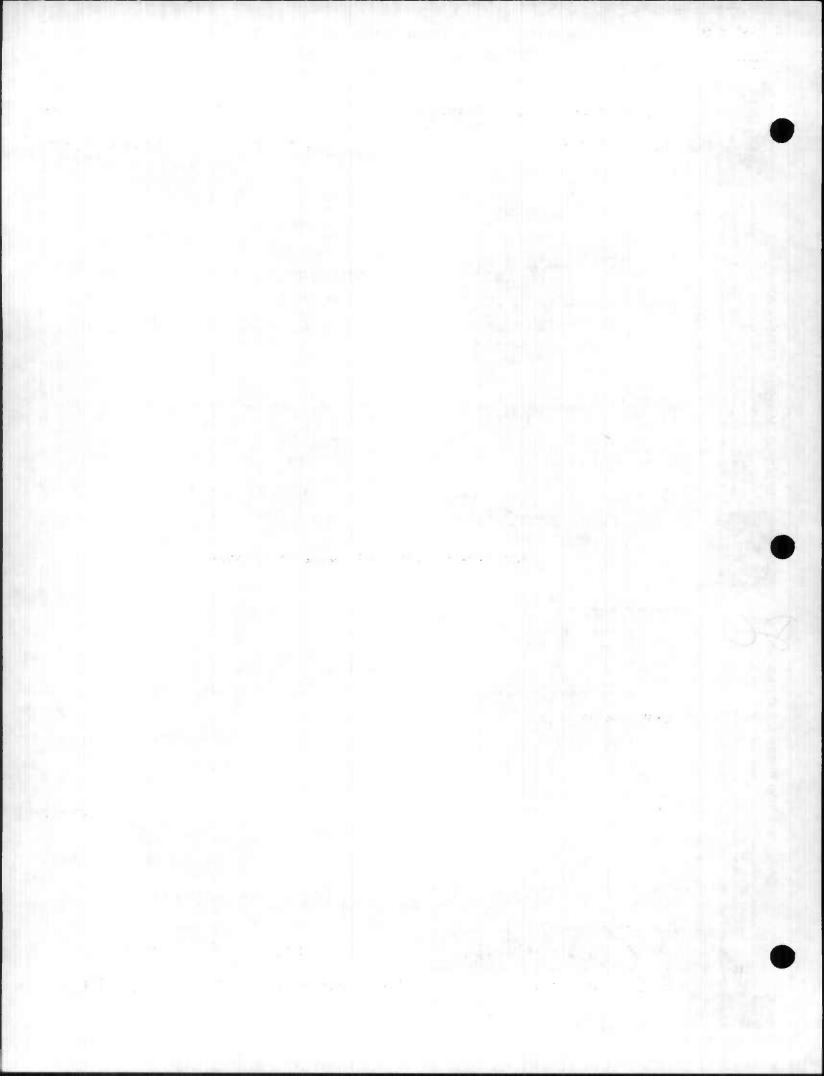
Laron Locke M.D. Registrar JUL 1 5 1998

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

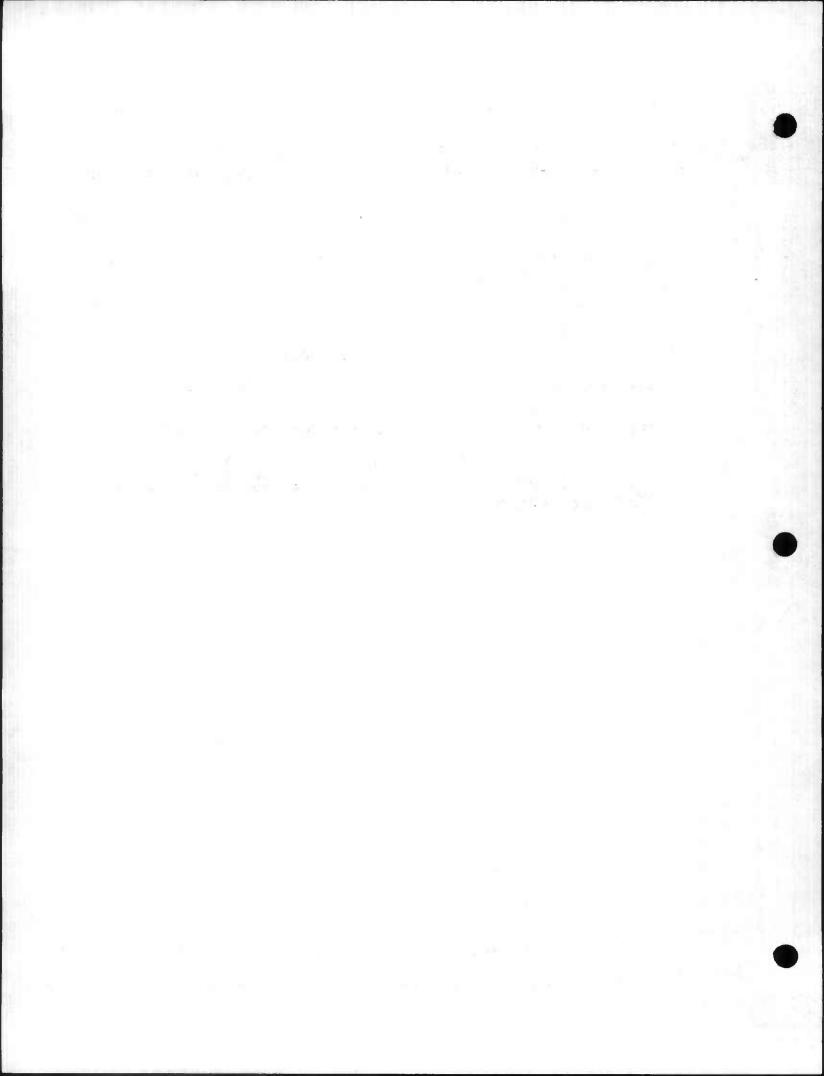
person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

					Olato of	iviaiyiai		rtificate of	Health and I f <i>Death</i>	Wichtai Try	Reg. No.	3 2	1681
	Di		1. Decedent's Neme (First,	Middle, Las	st)					2. Dete of De Month		Vaar	3. Time of Death
	Physici /Medio		TIMOTHY	EN	16L15H	,				JULY	Dey 10	Yeer 1998	1805
	Examir		4e. Facility Neme (If not ins						4b. City, Town, or	Location of Deet	th 4c. County	of Death	
1			CHURCH HO	ME	AND H	OS PIT	47.		BALTIN	MORE	130	RTM	0125
	Funeral Director		5. Social Security Number 213-70-226	6. S			lest birthdey) Yrs.	If Under 1 Yee Months Deys	r If Under 24 Hrs.	8. Dete of Bi	rth ey, Year) 29.194(Cour	olece (Stete or Foreign htry)
	P.		Usual Residence of Deced										
	ith the Marylar or 28a-f show a notified at		10a. Stete 10b. C		. 1	10c. Ci	ty, Town or Lo					1	10d. Inside City Limits
	M M	Director	MD	N/A	A			BALTO					Mes 2□No
	# 15 P	Sire.	10e. Street end Number					10f. Zip Code			10g. Citizen of	Whet Cour	ntry?
	23a		216 KENWO	OD A	V E			212	24		U.S	5 . A .	
	Herma Herma	Funeral	11. Meritel Status		12. Wes Dece	dent Ever in U	I,S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexicen, Puert	pecify Yes or No		ce - Americ	can Indian,
Maryland 21215-0020	a 9 5	by	1 XNever Merried 2 ☐ 3 ☐ Widowed 4 ☐ Div		1 ☐ Yes If Yes, Give Yeer or De	2 No		1 ☐ Yes 21 No		o riloan, etc.)		y: BL?	
0	72 hours	Completed	15. De	edent's Ed	ucation		16a. Dece	ient's Usuel Occi	upation	A LOSE	16b. Kind of B	usiness/Inc	dustry
21	S 9	ple	Elementery/Secondary (de com <i>pleted)</i> College (1-	4nr 5+)	life.	New York don't be not the control of	e during most of wored)	King			
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Pu	B = 0 5	Be (17. Father's Neme (First, M						18. Mother's Ner	ne (First, Middle	, Meiden Sumer	ne)	
la	should be nd Mental marked o	To	CALVIN EN	GLISH	Ŧ				NA	NCY HO	DLLEY		
an	2 sho and I is ma		19e. Intorment's Neme/Rei	etionship (7	Type, Print)		19b. Meilin	ng Address (Stree	et and Number or Ru	ıral Route Numb	er, City or Town	, State, Zip	Code)
	2 = 21 -		PATRICIA	JORDA	N		216	N. KEN	WOOD AVE	r RAT	TO MD	2122	2.4
ore.	ges 1 an it of Haal if item 2 or other		20e. Method of Disposition				Plece of Dispo	sition (Name of netory or other pl		Dete	TO MD 20c. Location	- City or To	wn, Stete
Ĕ	Pages nent of H int: If ite		1X Burial 2 ☐ Crem- 4 ☐ Donetjen 5 ☐ Ott			MT.		CEM		7-17-98	BALTO	. MT)
altimore,	pemit. Pag Department Important: If any Injury o		21. Signeture of Funerel Se	rvice Licen	500		22	. Neme end Add	ress of Fecility BE CAROLIN				
m	20 5 6		Paker	1	Beel	_	1	129 N.	CAROLIN	IE ST E	BALTO,	MD 2	21213
	_		23a. Part1. Enter the disee	se, or comp	olications thet ce	used the deel	th. Do not ent	er the mode of dy	ring, such es cerdied	or respiretory e	errest,	1	Approximete Intervel Between
	Physician		shock, or heart teilure	. List only	one cause on ee	ch line.						Ì	Intervel Between Onset end Deeth
a	/Medical		Immediate Cause (Final disease or condition			SYST	71.6					I	MINUTES
	Examiner		resulting In deeth)		θ		or as e consec	uence of):					
ш	D #	ner			MI	OCAK		INFA	or TIDAI				MINUTES
7	2 8	Examiner	Sequentially list conditions		b		or es e consec	-	CITON			1	.,,,,,,,,,,
6		Ä	Sequentially list conditions if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury		144	PERT	N510	N					YEARS
68760	physics physics the by	edical	thet initieted events resulting in death) Lest	5	c		or as e conseq			-			10103
	T 0 6		resulting in Coatiny Lost									İ	
Box	death certif a attending ed for usa as	Physician/M			d							1	
	dea na att	sici	Pert II. Other significant co	nditions co	entributing to dea	th but not res	uiting in the u	nderlying ceuse g	iven in Pert I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
P.0	res that tha de igned by tha a be detached (Phy	527	21111	E 01	CONIN	-77			10	Yes 2 No	3 Pro	bably 4 14 Hiknown
	gned be de	by		20,0	E N1-	30700	·/E						
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Re	The lay ate has page 2	E								10	Yes 2 No		Yes 2 No
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>		o Be	examiner? 1 ☐ Yes 2 ☑ No	-	Hospitel:	nationt 2	ER/Outpatler	1 312 DOA 0	26. Place of Dec		idence 6 🗆 Ott	or /Canail	541
		E	27. Menner of Deeth		28e. Dete of	Injury	28b. Time of	-			how injury occur		<i>y</i>)
Division	Attending F r death. ector: Aftar by tha funer	흩		ending vestigetion	(Month	, Dey Year)	Injury		ork?]Yes 2∐No				
/S	or Attendi after death. Director: A I in by tha fu	fica	3 ☐ Suicide 6 ☐ G	ould not be	28e. Plece o	of Injury - At h	ome, ferm, str	eet, fectory, office)		Street end Numi	ber or Rura	al Route Number,
á	after after Direct din b	Certification:	4 ☐ Homicide	0.011111100	bulldin	g, etc. (Specil	(y)			City or To	wn, State)		
	Hospital 24 hours a Funeral D letaly filled		29e. Certifier 1 🗗 Ce	rtifying Phy	vaicien: To the b	est of my kno	wledge, deeth	occurred et the	lme, dete end plece	end due to the	ceuse(s) end m	enner es s	teted.
	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completaly filled in by tha	edical	(Check only 2 Ms	dical Exam	iner: On the bas	is of examine	tion end/or in	estigetion, in my	opinion, deeth occu	rred et the time,	date end piece,	and due to) the ceuse(s)
	To the vithin 2 To the comple	Me	29b. Signeture end this of c	ertifier				29c. Licer	se number		29d. Dete signe	d (Month,	Dey, Year)
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	0		FRANCIS CA	NOIDIA	FN 9	BN	SROAD	WAY	# 307	BALTIA	your	110	21231
	Sta Registra	_	31. Date tiled (Month, Dey,	5 199 8	32. R	gistrer's Signe	low-Ran	face.					



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death FRIEND Month 700 PM **Physician** 5. WILLIAM 1998 JULY /Medical 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death Examiner NURSING CENTER MTER BAL.

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Month, Day, Year)

MONTH, Day, Year)

MONTH, Day, 1923 CANTON HARBOR 9. Birthplace (State or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) 2/8-16-4648 Usual Rasidenca of Decadent Yrs. Director filed within 72 hours after death with the Maryland 10d. Insida City Limits 10a State 10b. County 10c. City, Town or Location "natural", or items 23s or 28s-f show solds! Examiner, must be notified at MD. 1 Yas 2 No Director MORE 10e. Street and Number 10g. Citizen of Whet Country? 2934 U.5.A HUDSON ST 12. Was Decedant Ever in U.S. Armed Forcas? 1D Yas 2 □ No 1Yes, Giva Yaar or Datas: WWT Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorcad Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grada complated) Eiamantary/Secondary (0-12) Collaga (1-4or 5+) MECHANIC 12 BETH STEEL Deperment of Health and Mental Plant Important: If from 27 is mental Injury or other 27 is mental Injury or other 18 menta 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nema (First, Middle, Last) ROBERT VEKNA 0. 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) BALTO. MD. 21224 FRANCES FRIEND 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, crametory or other place) Data 20c. Location - City or Town, Stata ULV14 1 Burial 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Other (Specify) BALTO, MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** INFARCTION Immediata Causa (Finel disaasa or condition rasulting in death) /Medical 30 MIN ACUTE MYOCARDIAL Examiner Examiner DECLUSION CORONARY 30 MIN ANTERY physician end the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Ceusa (Disease or injury that initiated avents rasulting in death) Last ANTENIDACLEADSIS 10 YEARS CORONARY Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No CENEBROVASCULAR INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed HYPERTENSION 1 ☐ Yaa 2 ☐ No 25. Was casa rafarred to medical axaminar?
1 Yes 2 No Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Dev Year) 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Neturel 2 Accidant 5 Pending invastigation 1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28a. Placa of Injury - At homa, ferm, streat, fectory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and menner es stated.

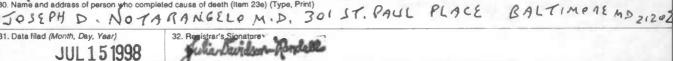
| Medical Examinar: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) To the complete 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of certifiar Notorangelo M.D. DO 7316 TULY 13-1998

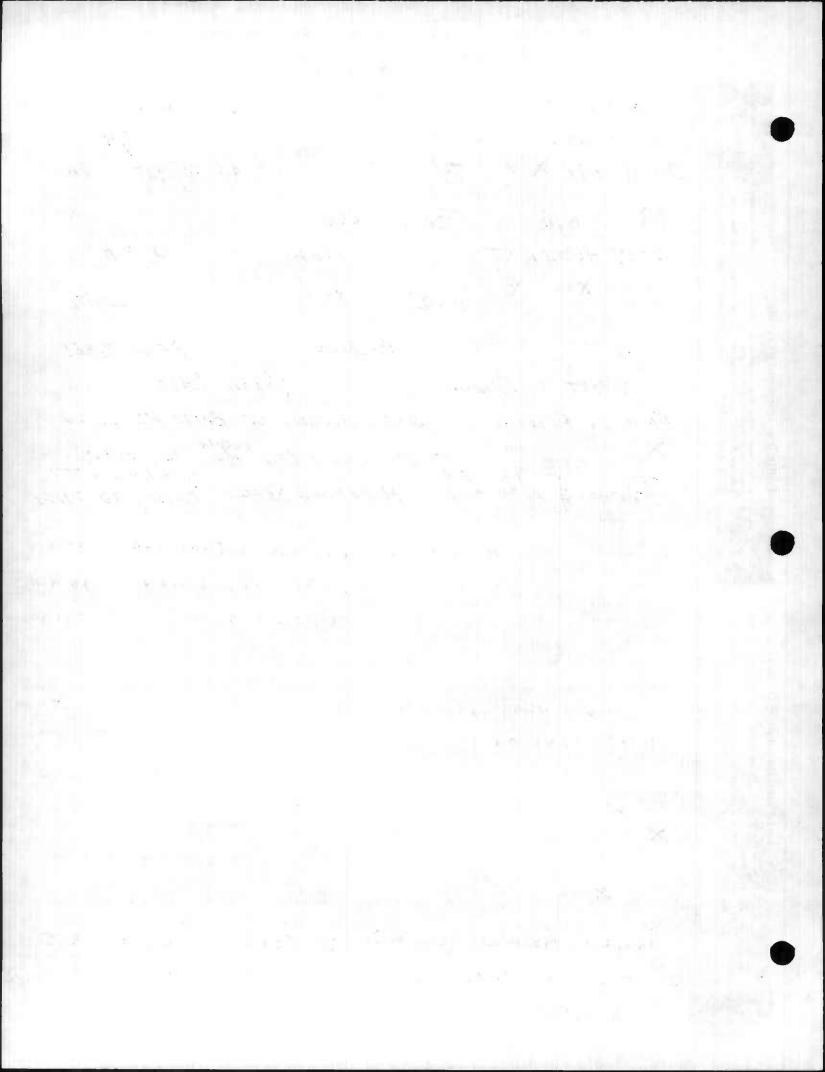
Registrar

31. Data filed (Month, Day, Year)

JUL 1 5 1998

30. Name and addrass of person who completed causa of deeth (Item 23e) (Type, Print)





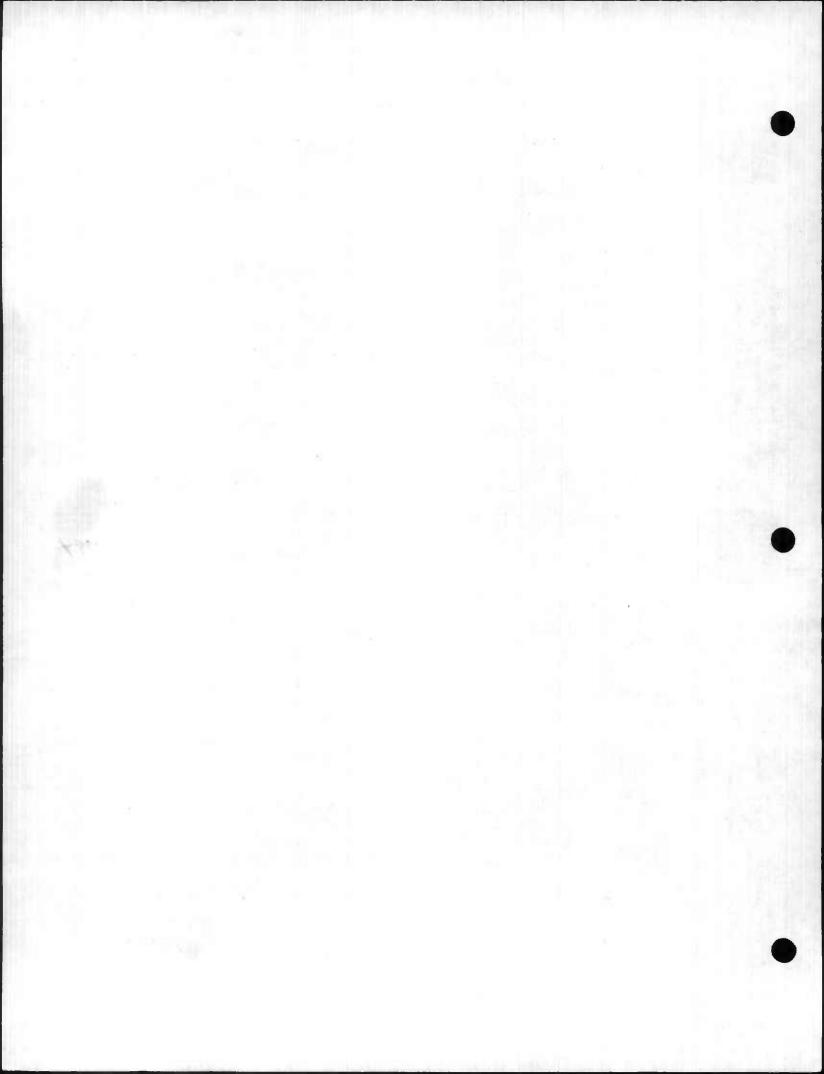
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Neme (First, Middla, Last) 2. Data of Death Day Year Month **Physician** 8:30 P.M FREMEAU JULY 8, 1998 HAROLD ROBERT /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE ANNE ARUNDEL 222 WILSON BOULEVARD if Under 1 Yaar 5. Social Security Number If Under 24 Hrs. 7. Aga (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1₽M 2□ F 578-09-1855 Director AUG. 11, 1911 MASSACHUSETTS 86 Usual Residence of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 10d. Inside City Limits MARYLAND ANNE ARUNDEL Director GLEN BURNIE 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 222 WILSON BLVD. 21061 U.S.A. death Funeral Was Decedant Evar in U.S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, Whita, etc. hours after 1 ☐ Yas 2X No if Yas, Giva 1 ☐ Nevar Married 2 ☐ Merried altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: WHITE p 3€Widowed 4 □ Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natu
any injury or other traumetic avent. the Mentine 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 11 NONE TERMINAL SUPERINTENDENT B.P. OIL COMPANY 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First Middle Maiden Sumame) Be JOSEPH FREMEAU 2 LOUISE BROUDER 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) LINDA L. BLAIR 222 WILSON BLVD. GLEN BURNIE, MARYLAND 21061 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burlel 2 ☐ Crametion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. LINCOLN CEMETERY 7-11-98 BRENTWOOD, MARYLAND 21. Signature of Funeral Se vice Cicensee 22 Nama and Addrass of Facility SINGLETON FUNERAL HOME SECOND AVE. S.W. GLEN BURNIE, MARYLAND 21061 24 Implications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, thy ona causa on aech lina. Approximate Interval Between Onset and Death **Physician** Dieno /Medical Immediata Cause (Finel diseasa or condition rasulting in death) **Examiner** 1000 Examiner (ADeros) ician and burial-transit that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Causa (Diseasa or Injury that initiated evants rasulting In death) Last Dua to (or as a consequence of): physician s the burial Box 68760 Physician/Medicai Dua to (or as a consequence of): US8 P.O. signed by the aid be detached t Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. Completed by 24b. Were autopsy findings available prior to should 24a. Wes an autopsy performed? completion of cause of death? page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case refarred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of After 1 Neturel 5 Pending 1 Yas 2 No death. 2□ Accident Investigation 24 hours after deat Funeral Director: 6 Could not be datermined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicida 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ HomicIda filled in Hospital Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steled. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 7/10 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

ours -

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OAKEJOUS NO GLES AMIEND 21061



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Neme (First, Middle, Last) 3. Time of Death 15 Am Month **Physician** REEN MARGAREI /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Balto 4 TOUSON If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** Months 21318 1□M 2▼F 9 0 Yrs. 2575 Director Ma Usual Residence of Decedent the Marylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours efter death with the Maryle Heelth and Mental Hygiene. The merked other than "naturel; or items 23a or 28s-f show wither treumatic event, in a fedical Exament must be notified at Balita 1 Yes 2 No N.A Md Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 CLIFTVIEW U.S. A 1709 AYE Funerai 12. Wes Decedent Ever In U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien. 11. Marital Stetus Bleck, White, atc. 1 ☐ Yes 2 No If Yes, Give Yaar or Datas: 1 ☐ Never Merried 2 ☐ Married Maryland 21215-0020 1 Yas 2 No Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 5011 House Keeper 10 grade 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) RHARLES WILLIAMS SARAL MACK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Peges 1 and 2 ment of Heelth e 5 mith 3ALTO, Md 21218 JEAN AY. 1709 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State 4 Donetion 5 Other (Specify) Department of Important: If eny injury or ò 7/14/54 A.A. COUNTY HILL Cen COLAR 21. Signature of Funeral Service Licensee Fineral Home 1304 h Locks Report Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediete Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Examiner physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest dia P.O. Box 68760. Physician/Medical Due to (or es e consequence 88 use signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the undarlying ceusa given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were eutopsy findings evelleble prior to completion of causa of death? 24e. Wes en eutopsy performed? Completed 1 Yes 3 No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Tospical 2 1□ Yes 2☑ No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Certification: After or Attending 1 Neturel 5 Pending 1 Yes 2 No 24 hours after death. investigation 2 Accident 6 Couid not be determined 3 Suiclda Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1/2 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner as stated.
2 Medical Examinar: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) within 2 \$ 29d. Dete signed (Mooth, Day, Year) 29c. Licanse number 29b. Signature and ting of certifie 0

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BALTIMORE

E. JOPPA Rd

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Registrar

DHMH 16 Rev 6/95

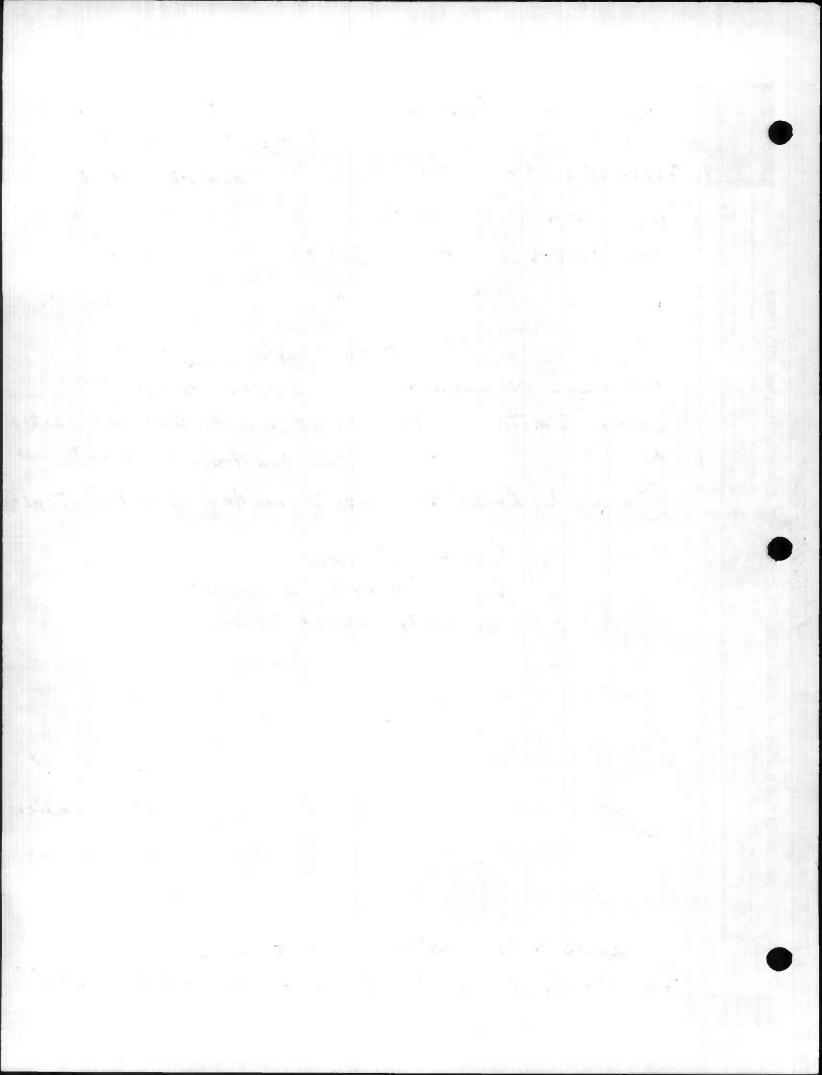
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31. Dete filed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

JUL 151998

32. Registrar's Signature



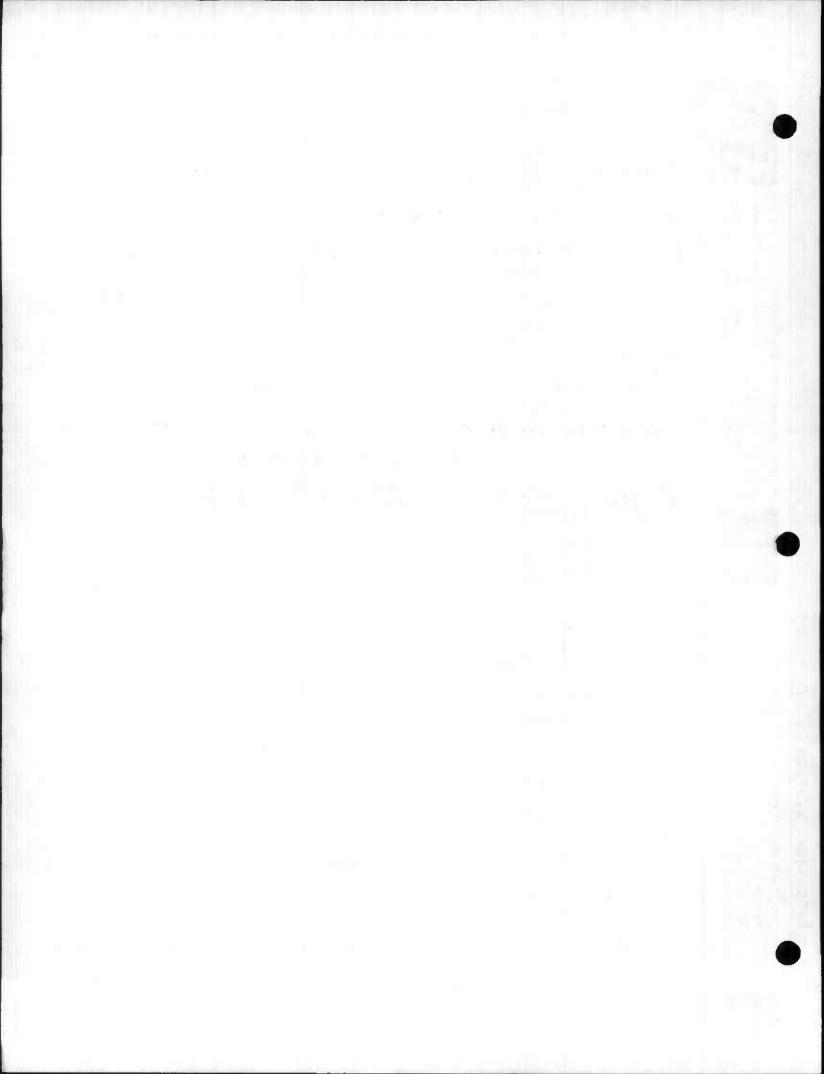
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						Cer	tificate c	of Death		B	eg. No.			
			1. Decedant's Name (First, Middla, Le	ist)						2. Dete of Dee	th		3. Time	a of Death
	Physic		ALICE BESSIE GR	OGAN						JULT	Dey	Yaar Q Q	141	5 HRS.
8	/Medi Examii		4e. Facility Name (If not institution, gh)			4b. City, To	own, or Lo	cation of Death	4c. County		1	
7	E-Xaiiiii	IGI	ST AGNES HOSE					04	TIM	ORE		NIA		
1	Funeral				ga (In yrs. lasi	t birthday)	If Undar 1 Ye						lace (Stat	ta or Foreign
L	Director		219-14-0355 Usuel Rasidance of Decedent	4DM 6DE	2	Yrs.	Months De	ys Hours	Min.	8. Data of Birth (Month, Day JULY 17	,1925	MAR	YLANI	ta or Foreign
	ter death with the Marylenc flems 23s or 28s-f show free mast be notified at	Ļ	10a. Stata 10b. County MARYLAND BALTII	MORE.	10c. City, T	own or Loc						1		City Limits
	No M	Director											1 U Y	as 210 No
	# 2 F	품	10e. Street and Number				10f. Zip Cod			1	0g. Citizan of		ntry?	
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	ep.	Funeral	11. Maritai Status	12. Was Decedent Armed Forcas	Ever in U,S.	13. W	/as Decedent o	of Hispenic Or	igin? (Spe	ecify Yes or No- Rican, atc.)	14. Rac	ce - Americ		
020	hours after death with the Marylend tural; or items 23a or 28a-f show at Examiner must be notified at	þ	1 ☐ Never Merrled 2 ☐ Married 3 🛱 Widowed 4 ☐ Div <i>o</i> rced	1 ☐ Yas 2 ☑ If Yas, Giva Yeer or Datas:			□Yas 2011			,		y: WHI		
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12	d within piene. r than	E E	Elemantary/Secondary (0-12)	Collaga (1-4or	5+)			rired)						
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Maryland	S d is D	Be	17. Fathar's Nama (First, Middla, Last	•						(First, Middla,		na)		
7	should be fand Mental bar marked of	2	CHARLES M. ALBII				<u>-</u>	E	AGNES	MARY G	RAFTON			
Ja	2 9 8 8		19a. Intermant's Name/Ralationship (Type, Print)		19b. Mailing	Address (Stre	aat and Numb	er or Rura	al Route Number	r, City or Town	, Stata, Zip	Code)	
	permit. Pages 1 and 2 should Department of Health end Mer Important: If Item 27 is marke any Injury or other traumatic ance.		MARY A. POSTANO	WICZ (DAUG	HTER)	844	1 WILLO	W_GLEN	L_CQU	RT - MA	NASSAS,	VA.	2011	0
0	of H		20e. Mathod of Disposition 1 ☐ Burial 2 ☑ Crametion 3 ☐	Bamaval from State	20b. Plac	e of Dispos	ition (Nama of atory or other p		ì	Data	20c. Location	- City or To	wn, Stata	
3	Pag ment ant: I		4 □ Donation 5 □ Othar (Special		BALTO	/WASH	INGTON	CREMAT	ORY	7/14/98	LAUF	REL, 1	MD	
Baltimore,	permit. Pages 'Department of H Important: If he any injury or of		21. Signature of Femeral Service Lice	nsaa		22	Name and Add BBARD I	drass of Fecili	ty HOM	E INC				
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	Sta	ite	31. Data tiled (Month, Day, Year)	32. Registr	rar's Signature	on-Ron	delle-							

DHMH 16 Rev 6/95

State Registrar

NAME GROGAN, ALLCE



98-3997-005

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DOROTHY

State of Maryland / Department of Health and Mental Hygiene

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29d. Dete signed (Month, Day, Year)

JULY 12,1998

GAMBER
Physician
/Medical
Examiner

Funeral Director

with the Maryland Hem 27 is marked other than "natural", or Hems 23s or 28s-f show other treumstic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death vacapartment of Health and Mental Hygiene.
Important: if Item 27 is marked other than "natural", or itema 23a any Injury or other treumatic event, the Medical Examiner manages. Baltimore, Maryland 21215-0020

Physician /Medical Examiner

the attending physician and hed for use as the burial-transit signed by

The law requires that the death certificate be axed Division of Vital Records, P.O. Box 68760, After this certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

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	10e. Street and N	umber					101.	Zip Code			10	og. Citizen of	Whet Cou	ntry?	
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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 XMedicel Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

State Registrar

Medicai

29a. Certifier

(Check only one)

29b. Signature and title of certifier

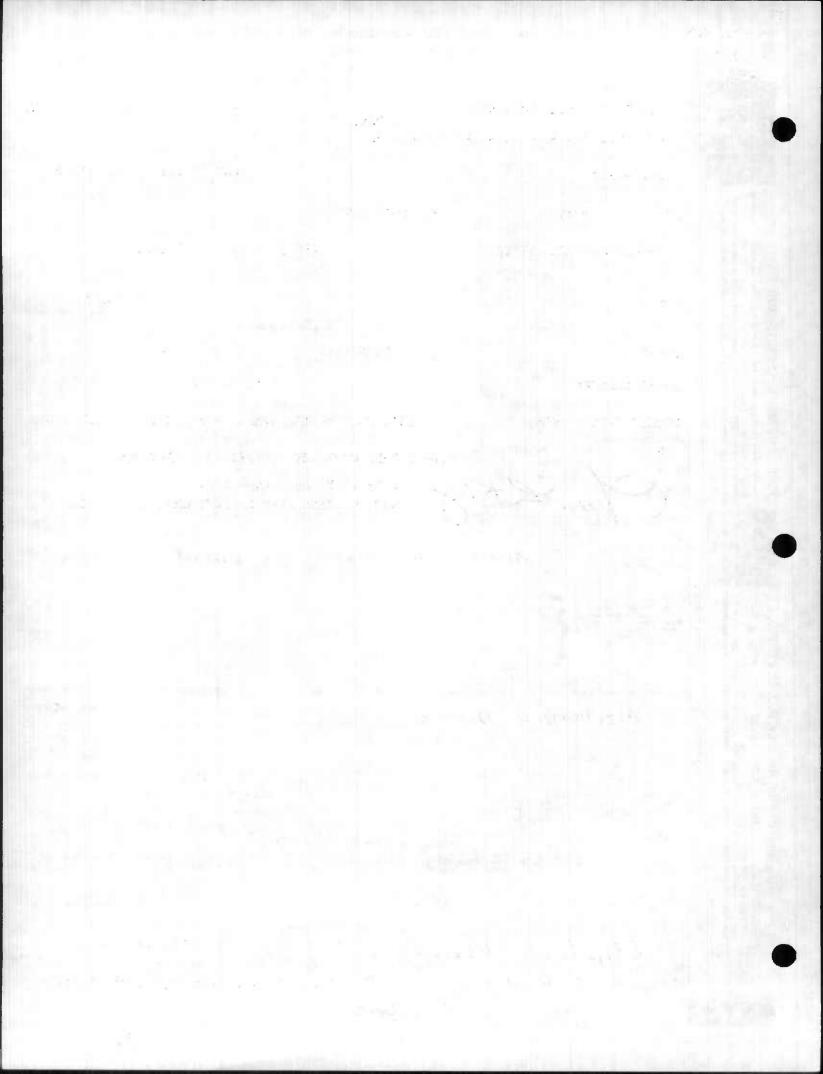
Radentz Stephen 5.
31. Dete filed (Month, Day, Year)

IUL 1 5 1998

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 the Davidson-Randall

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** 6:50p.m. JULY EDWARD HANDS /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** STELLA MARIS HOSPICE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** Days 1 M 2 □ F Months Hours 217-09-7607 MARYLAND Director 82 MARCH 10,1916 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. Stete 10c. City. Town or Location or 28a-f show 10b. County 10d. Inside City Limits 1X Yes 2 No Directo MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itema 23s or edical Expressment must be U. S. A. 5080 ORVILLE AVENUE 21205 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (1) No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced WHITE Hygiene. other than "natura ent, the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BALTIMORE Elementery/Secondary (0-12) College (1-4or 5+) 9th GRADE BRICKLAYER GAS & ELECTRIC COMPANY marked other 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Meiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 is marked oth Be JOHN HANDS EDNA WILLIAMS 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BEVERLY HANDEL (DAUGHTER) 804 FOXWELL ROAD, JOPPATOWNE, MARYLAND 21085 item 2. 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State = 5 4 ☐ Donetion 5 ☐ Other (Specify) GARDENS OF FAITH 7/11/98 BALTIMORE, MARYLAND 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME INC 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PAROTID GLAND CANCER Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or as e consequence of): P.O. Box signed by the a Part !!. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert !. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Onknown Records, by 24b. Were autopsy findings evailable prior to completion of ceuse of death? 24e. Wes an autopsy performed? eted certificate has b Compi 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2√200 Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: Attending 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No death 2 Accident or Attendation of Director: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the Funeral Director of the Fu 3 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I made it is provided by the cause of the cau edical 29a. Certifier within 24 ho To the Fune completely fi (Check only one) of contition 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License gumber 15506 7.9.98

Registrar

State

30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print)

2300 DULANEY VALLEY RD.

who Davidson

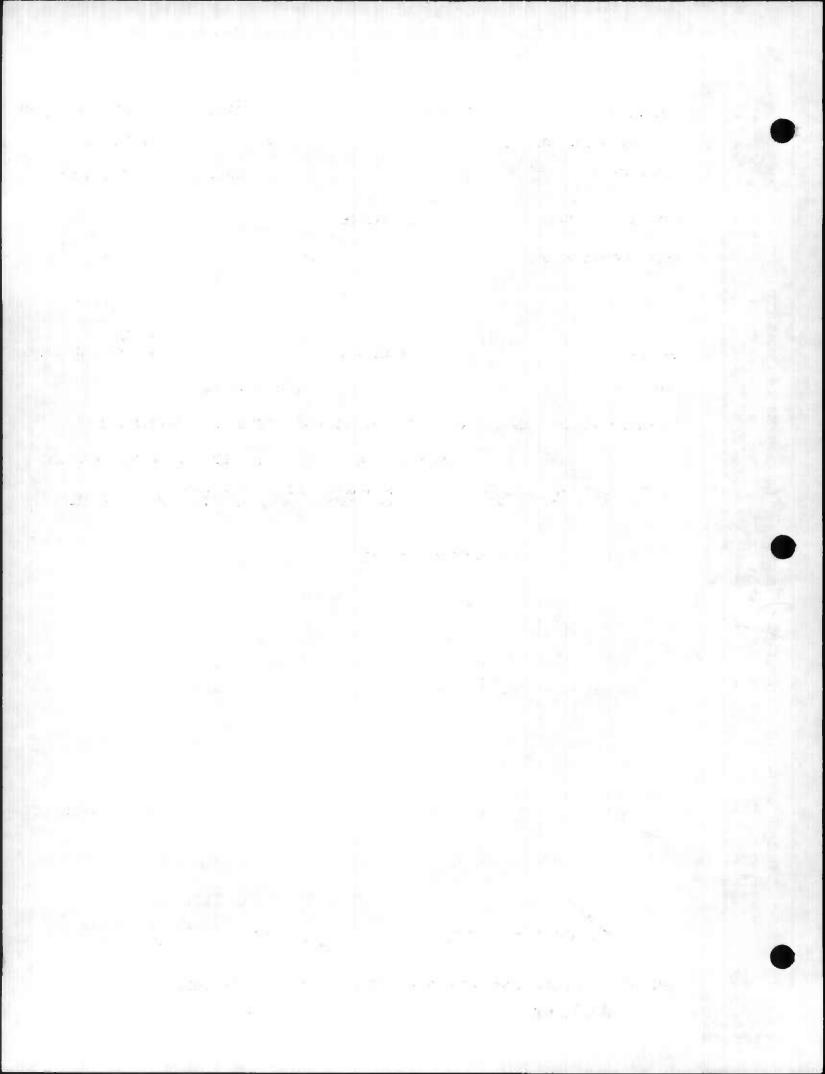
- Mandalle

32. Registrans Signature

TIMONIUM, MD 21093

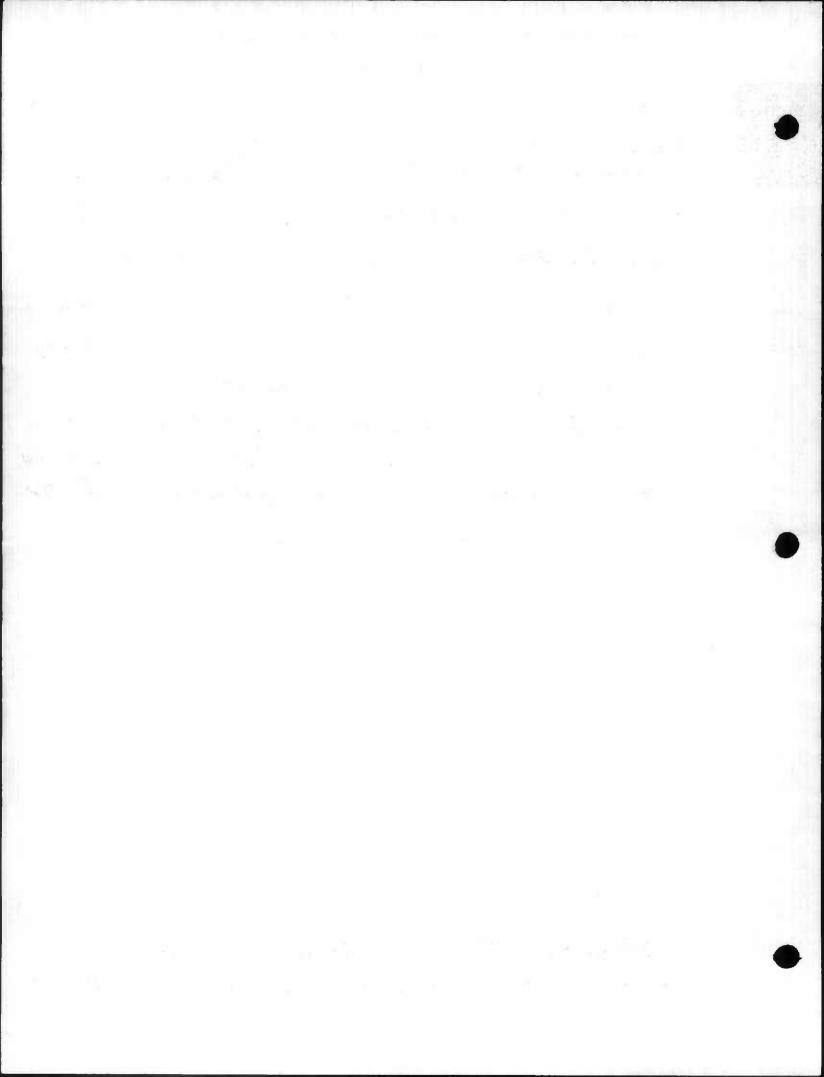
DR. EDDIE NAKHUDA

31. Date filed (Monti



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hyoiene

			Certificate of Death		leg. No.	21688
	Dhysisi		1. Decedant's Nama (First, Middle, Last)	2. Data of Dea Month		3. Tima of Death
	Physici Medio/		BERTHA M. HALL	JULY	12 199	11:25 Pm
3	Examir	er	4e. Facility Nama (If not institution, give street end number) VILLA ST MICHAELS 4b. City, Town, or Lo		4c. County of De	
-	Francis					
	Funeral Director		Usual Rasidanca of Dacedant	8. Data of Birth Month, Day	, Year)	irthpiaca (Stata or Foreign Country) Ni
	nyland	en.	10a. Stata 10b. County 10c. City, Town or Location		-014	10d. Insida City Limits
	Se-f	ecto	Md N.A. BALTO			1 Mayes 2 □ No
	with the	Funeral Director	10e. Street and Number 10f. Zip Coda		10g. Citizan of What (
	Jeath rie 23	era	11. Marital Status 12. Wes Dacedant Evar in U,S. 13. Was Decedant of Hispanic Origin? (Spe	cify Yes or No-		nerican Indian,
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglane. Important: If item 27 is marked other than "naturet", or items 23a or 28a-f show stay filutry or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 12. Was Dacedant Evar in U,S. Armed Forces? 1 □ Navar Married 2 □ Married 1 □ Yas 2 ☑ No If Yas, Giva Yeer or Datas: 13. Was Decedant of Hispanic Origin? (Spe If Yas, specify Cuban, Maxican, Puarto I 1 □ Yas 2 ☑ No I □ Yas 2 ☑ No Specify:	Rican, atc.)	Biack, Wt	
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Baltimore,	Pages 1 nent of H int: If iten		20a. Method of Disposition 20b. Plece of Disposition (Nama of cematary, cramatory or other placa)	Data	20c. Location - City of	
Itim	it. Par rtant: njury		4 Donation 5 Other (Specify) MT ZION CEM.	118198	LANds	downe. Ad
Ba	permit. Departr Imports eny inje		21. Signeture of Funaral Sarvica Lipansee 22. Nama and Address of Facility Locks Funeral	Home.	1304 71	Central ag
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).	Physician /Medical	Н	immediate Causa (Finai			
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Divi	or Attancattance after death	ertif	4 ☐ Homicide datarmined datarmined 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify)	City or Tow	n, Stete)	Hurar Houta Wumber,
_	To the Hospital or Attanding Phwithin 24 hours aftar death. To the Funeral Director: Aftar thicompletaly filled in by the funaral	O	29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, a	and dua to the o	ause(s) and mannar	as stated.
	he Ho in 24 he Fu pletat	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurre and manner stated.	ed at the tima, o	late end place, and d	ua to the ceuse(s)
	With To to	Σ	29b. Signeture and titla of cartifiar		29d. Data signed (Mo	nth, Day, Year)
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			30. Nama and eddrass of parson who completed cause of death (Itam 23a) (Type, Print)	0	ELIAL SAF	MA TIEND
	Sta	e	DEBOVAH I PIERCE 7200 PARK ITGHTS AVENUE 31. Deta filed (Month, Dey, Yaer) 32. Registrar Signature	DHL	IVNOKE,	110 2/208
	Registr		JUL 151998 > Julia Davidson-Rondon			



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Examir		4e Fecility Name (If not institution, g	give street and number)							ation of Deeth	4c. County	of Death	
		North Arundel	tosnital				1	alen G	Burn	ie	Anne	Aru	ndel
Funeral				e (In yrs. last	birthdey)	If Under 1	ear	If Under 24 Hours	Hrs. I	8. Dete of Birth	Veer)	9. Birth	place (State or Foreign
Director		217-05-9582	1□ M 2 X F	95	Yrs.	I WOTHING E	uys	110013		(Month, Dey, Sept. 5	,1902	Ma	aryland
		Usuei Residence of Decedent		T									
a tar		10a. Stete 10b. County	Arundel	10c. City, T		vel Be	aak	Dood.					10d. Inside City Limits
18	Director	Maryland Anne	Arunder	140	Cai	ACT De	acı	1 ROAU	BA	LTIMORE			1 ☐ Yes 2 No
or 28	Oire	10e. Street and Number				10f. Zip Co				1	0g. Citizen of		intry?
23a		146 Carvel Bea	ch Road				23	1226			U.S	.A.	
, or items 23s or 28s-f show	Funerai	11. Maritel Status	12. Was Decedent Armed Forces?	Ever In U,S.	13.	Was Deceden	t of Hi	ispanic Origin	n? (Spec	cify Yes or No-		ce - Ameri ck, White	ican Indian,
or its		1 Never Married 2 Married				1 ☐ Yes 2				, , , , ,		v: Whi	
2	by	3 M Widowed 4 □ Divorced	Yeer or Detes:				140	эреспу.			Specin	A. AATTT	
Part.	Completed	15. Decedent's (Specify only highest)	Education grade completed)	1	(Give	dent's Usual (fone o	during most o	of working	g I	16b. Kind of B	usiness/î	ndustry
than to	npl	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. I	DO NOT use	etired	0					m.2
ther th	Co	8	00		Car	eteria	Ma						Education
0 >	o Be	17. Fether's Name (First, Middle, La Albert	Anthony					_	s Name nna	(First, Middle, I Burr		ne)	
27 is marked treumatic		19a. Informant's Neme/Relationship Charmaine Lewi								Route Number			ip Code) land 21226
nt: If Item 27 Iry or other to		20a. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donation 5 Other (Spe		ceme	etery, crer	sition (Neme netory or other ren Men	r piec		rk 7		20c. Location Glen B	1	own, State e, Maryland
Important: any injury		21. Signature of Funeral Service Lic	ensee		1								ral Home d 21122
ysician		23a. Pert1. Enter the disease, or co shock, or heart failure. List on	implications that caused ly one cause on each lin	the death. I	Do not ent	ar the mode of	d dyin	g, such es ci	ardiec or	respiretory err	est,		Approximete Interval Between Onset and Death
ledicai		Immediate Cause (Finel disease or condition	Conge	ture	Herr	1- F	21	lune					4 years
aminer		resulting in deeth)	. Conges	Due to (or as	a consec	quence ot):							1 /
.=	iner		. co Rone	ary 1	4-12	W :	Da	same.				· ·	4400
and I-transit	xaminer	Sequentially list conditions,	D	Due to (or es	e consec			- Parker					Many
ician ar burial-t	ш	if eny, leading to immediate cause. Enter Underlying	Hungart	0100 :-	-							1	yean.
75	Ica	Ceuse (Disease or Injury that Initiated events resulting In death) Lest	c. They	Due to (or es	a conseq	uence of):						+	15
O O	Med	resulting in death) Lest											
use	ZE		d									1	
the att	Sici	Part II. Other eignificent conditions	contributing to death b	ut not resultin	g in the u	nderiying ceu	se giv	en in Part I.		23b. Dld to	obacco uee co	ontribute	to the cause of death?
ed by the	Physician/Medical									1□ Y	ee 2□ No	3□ Pr	obably 4⊠ Unknow
s been sign should be	Completed by									24a. Was e perfor		8	Vere autopsy tindings wailable prior to completion of ceuse of death?
2 8	EO									1 □ Y	es 2 No	1	☐ Yes 21 No
8													
	0	25. Was cese referred to medical						26. Place o	of Deeth	(Check only or	ne)		
s certificate director, per		25. Was cese referred to medical exeminer? 1 ☐ Yes 2 ☑ No	Hospitel:	ent 2□ER	/Outpatier	nt 3 DOA	Oth	or.		(Check only or		her (Spec	elfy)

To the Hospital or Attending Physic within 24 hours effer death.

To the Funeral Director: After this co completely filled in by the funeral dire Division of

Many Halm.

Medicai Certification: To

1 Yes 2 No 27. Manner of Death 1 Maturel

2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

28d. Describe how injury occurred

29b. Signature and title of certifier

29a. Certifier (Check only one)

House Stafe

29c. License number DS1596 29d. Date signed (Month, Dey, Year) 1998

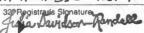
30. Name and address of parson who completed cause of death (Item 23e) (Type, Print)

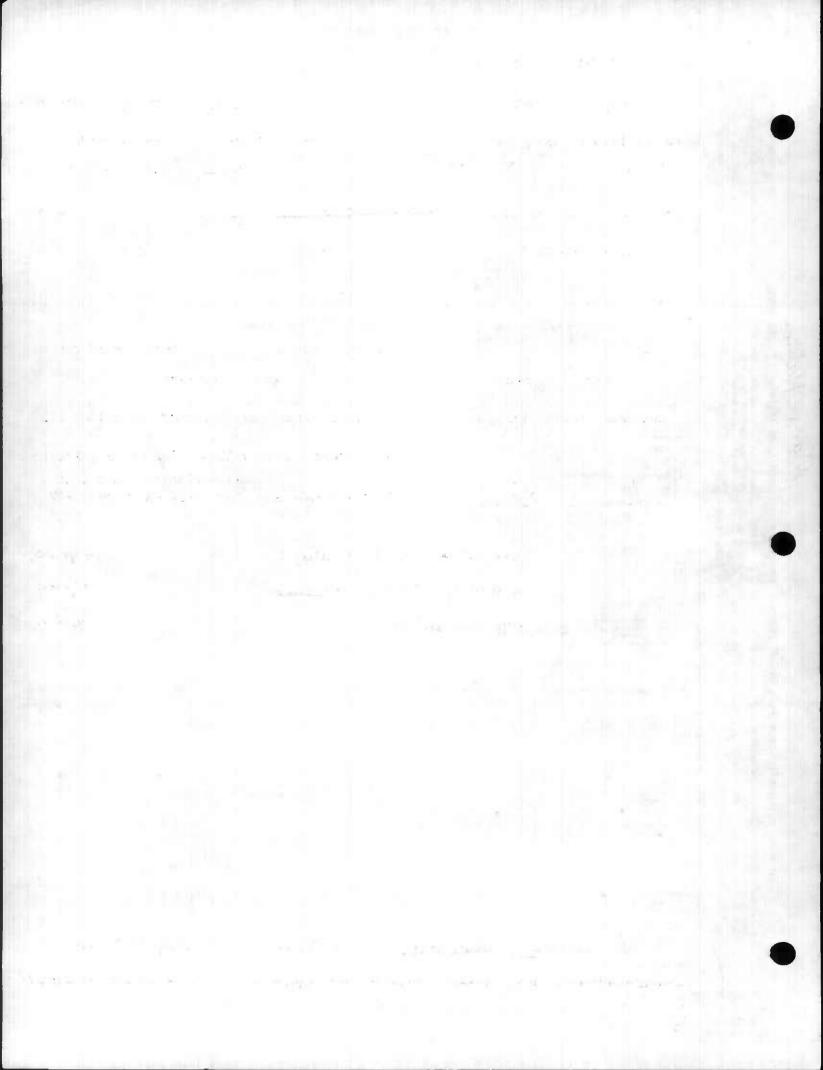
NORTH ARUNDEL HOSPITAL, 301, HOSPITAL DRIVE, GUEN BURNIE MD 21061 K. AMBALAVANAR,

State Registrar

31. Dete filed (Month, Day, Year)

JUL 15 1998



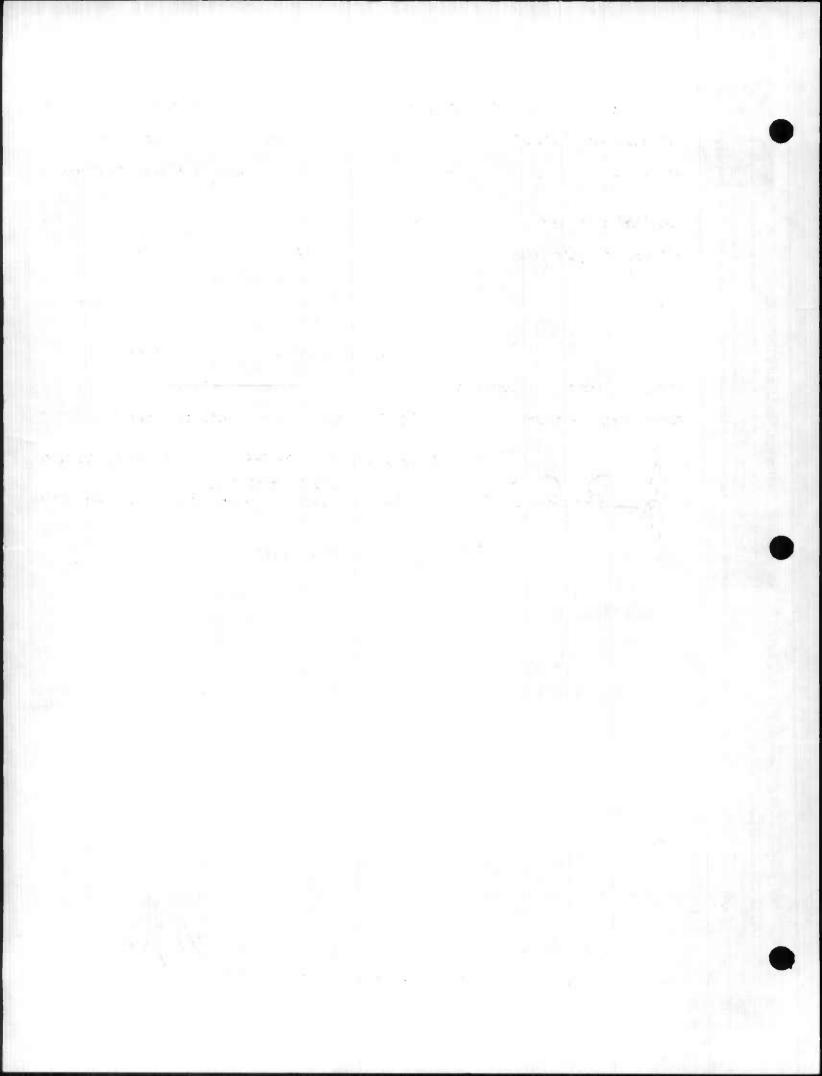


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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death ITEM: #18 PER INFORMANT G762 8-3-98 WR. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 9,1998 12:44 pm Edward Hartlove Clarence /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Baltimore 331 St. George's Road Essex 8. Date of Birth (Month, Day, Year) NOV 21, 1921 If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Months Days Hours Min Maryland 76 Yrs 212 12 4215 **Director** Usual Residence of Decedent the Meryland 10a State 10h County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or frems 23s or 28s-f show treumstic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 21221 331 St. George's Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Biack, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours after a Department of Heelth and Mental Hygiene. Important: If frem 27 is marked other than "natural", or free any injury or other treumetic event, the Madical Environments. 1 Yes 2 No If Yes, Give Year or Dates: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: p White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Machine Operator Steel Mill 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hartlove Myrtle Groves **James** Henry MABEL IRENE GROVES 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6506 Baltimore Avenue Baltimore Maryland 21222 Debra Emkey (niece) 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burlat 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 7/13/1998 Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Addrass of Facility Bruzdzinski Funeral Home PA 21. Signature of Funeral Sarvice Licenses 1407 Old Eastern Avenue Essex, Maryland 21221 In Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death **Physiclan** Oveney a stery disease immediate Cause (Final disease or condition resulting in deeth) /Medical **Examiner** Due to (or as a consequence of) Examiner physician and the buriel-trensit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): for use as 50 23b. Did tobacco uss contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Hunknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? peed certificate has 1□ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: Affer Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident ofter death Director: 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 6 Hospital 24 hours 29a. Certifier (Check only one) 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Within 2 and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signature and title of carrier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sheldon Milner Md 404 Eastern Blvd Essex, Maryland 21221 Sheldon Milner Md 31. Date filed (Month, Pall Year) 5 1000 32. Registrar's Signature rune sheet hours forder Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #20b,c Per FH Film G761 7-16-98RC Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Deeth 08 35 Day Month **Physician** LERNOON WILLIAM 1998 14 JULY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner BALTIMORE N/A BALTIMORE HOSPITAL OF If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2□ F 64 216-30-5959 Yrs. 10/19/1933 Director Maryland Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits ehow "naturel", or items 23s or 28s-f show MD N/A Baltimore TØ Yes 2 □ No Director 10e. Streel and Number 10f. Zip Code 10g. Citizen of Whal Country? 3800 W. Belvedere Avenue 21215 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No It Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, While, etc. d 2 should be filed within 72 hours effer of the and Mental Hygiene.
7 Ie merked other than "naturel", or fler traumatic event, the Medical Examines. 1 Never Married 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Time Realty Elementery/Secondary (0-12) College (1-4or 5+) Maintenance 12th 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Peges 1 and 2 should be nent of Heelth and Mental William Herndon, Sr. Laura Neuman 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. tnformant's Name/Retationship (Type, Print) Department of Heelth at Important: If Item 27 le eny injury or other tratonce. Doris W. Herndon 3701 Hillsdale Road, Baltimore, Md. 21207 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Siete Randal Istown, Md. 7/21/98 1 XBuriel 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Cem. Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park
22. Name and Address of Facility
LEROY O. DYETT 21. Signal of Funeral Service License & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD or complications that caudest only one ceuse on each the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Intervel Between Onset and Death ter the disease **Physician** METASTATIC LUNG CANCER /Medical Immediate Ceuse (Finel ZYEARS disease or condition resulting in death) Examina Examiner The law requires that the death certificate be executed physician and the burial-tran Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): for use as signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown CHRONIC PANCREATITIS þ 24b. Were autopsy findings available prior to completion of cause of death? should Completed 24e. Was an eutopsy ils certificate has director, page 2 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) 1 ☐ Yes 3 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To this 28e. Dete of Injury (Month, Dey Year) 27. Menger of Death 28d. Describe how triury occurred 28b. Time of 28c. Injury et Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No

Attending Physician: funeral After death. after death Director: /

Division of Vital Records. To the Hospital or A within 24 hours after To the Funeral Direcompletely tilled in b

edical

RIC 31. Date filed (Month, Dey, Yeer) State JUL 151998 Registrar

2 Accident

4 Homicide

29b. Signature and title of certifier

3 Suicide

29a. Certifier

Investigation

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

SINAI HOSPITAL OF BALTIMONE CARR, MO

329Registrate Signeture Randall

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

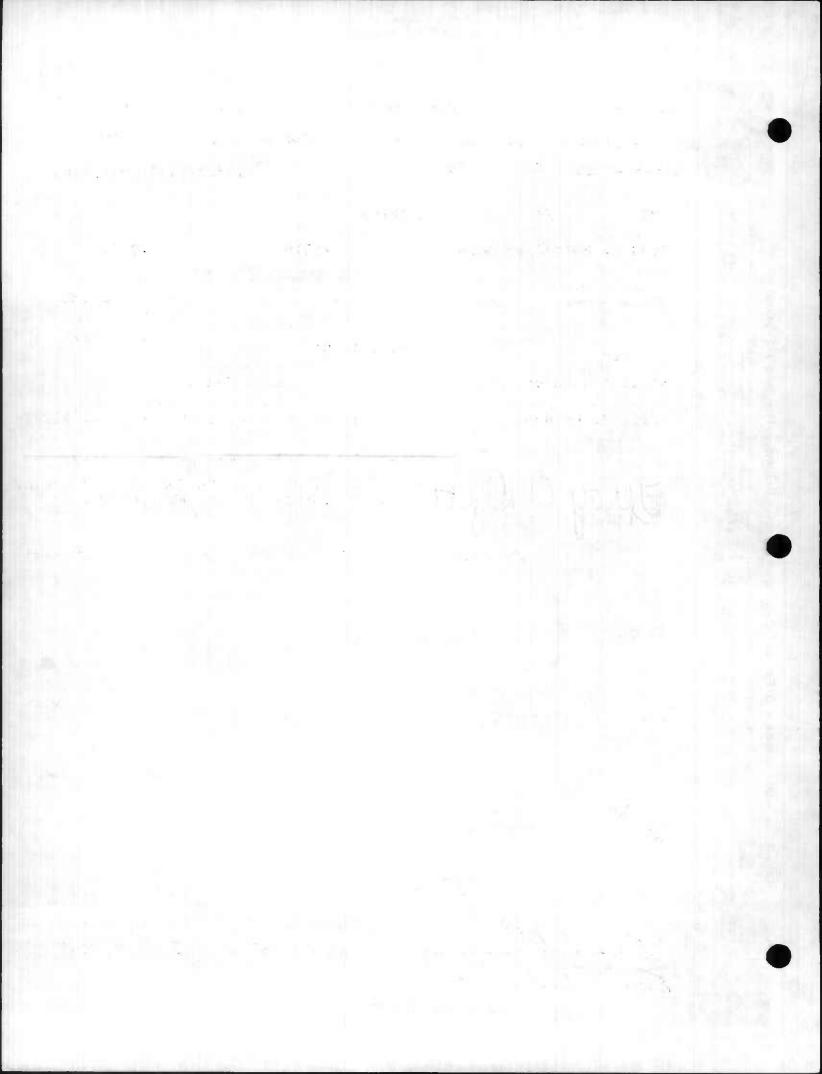
29c. License number

00053095

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Day, Year)

July 14, 1998

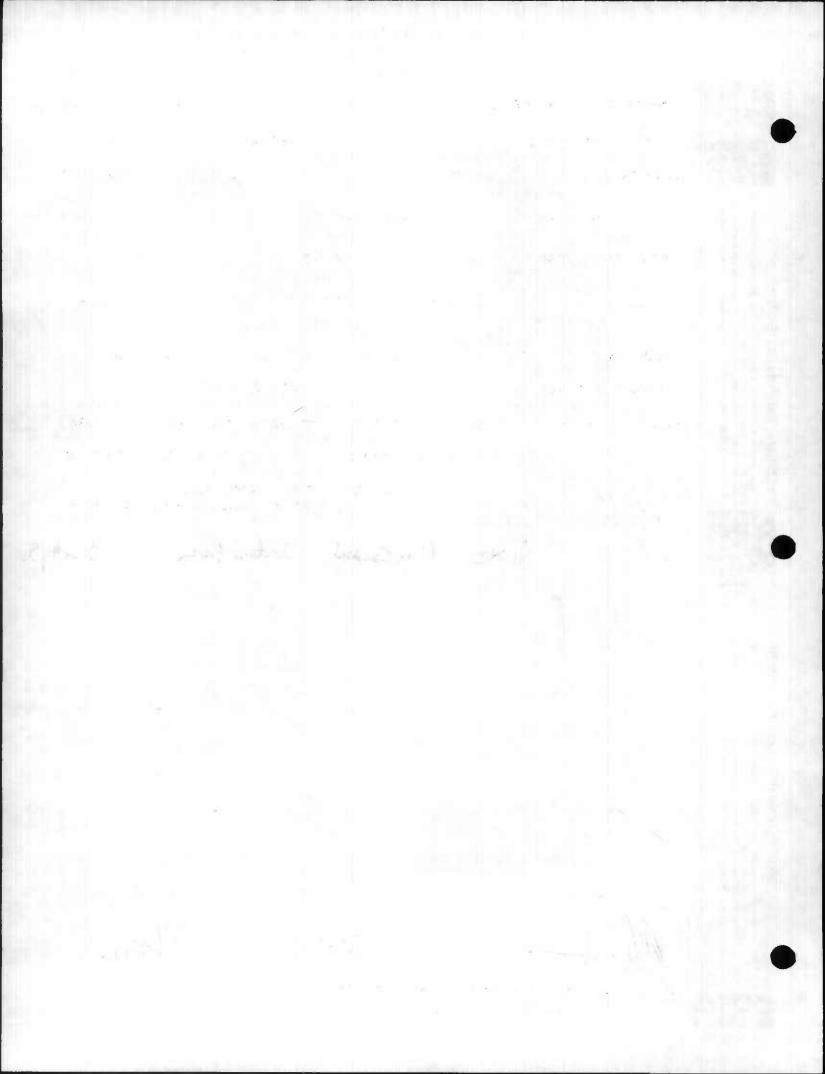


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State of Maryland / Department of Health and Mental Hygiene Q 2

lalaa					-	Certificate	UIL	Calli		H	leg. No.			
	1. Decedent's Ne	me (First, Middle, La	est)							2. Dete of Dee Month			Year	3. Time of Deeth
ysician Medical	FREDER	ICK E. H	HADERMAN							JULY	11,			1:30P.M.
caminer	4e Facility Neme	(If not institution, given	ve street and numb	ber)			4b	. City, To	wn, or Lo	cation of Death	4c. Co	ounty of	f Death	
	3505 I	LOSRAC COL	URT					PARK		E	BA	ALTI	MORE	
ral tor	5. Sociel Security 160–18–0 Usuel Residence	0157	Sex 7 1 ☑ M 2 □ F	. Age (In yrs	. last birthe	Months [Yeer Days	If Under:	24 Hrs. Min.	8. Dete of Birth (Month, Dey 8/15/2	, Year)		9. Birthple Count MARY	
	10a. Stete	10b. County		10c. C	ity, Town	or Location							10	d. Inside City Limits
Puneral Director	MD	BALTIM	ORE		P	ARKVILLE								1 ☐ Yes 2X No
Director	10e. Street and N		01(13			10f. Zip C	ode				10g. Citize	on of Wh	nat Count	rv?
ā		OSRAC COUL	DΨ				2123	2/1				USA		
era	11. Maritel Stetus		12. Wes Deced	ent Ever in U	J.S.				aln? (Spe	ecify Yes or No-	14		- Amarica	ın Indien,
by Funeral	1 Never Ma	rried 2 Merried	Armed Ford 1 1 Yes 2 If Yes, Give Yeer or Dat	es?		13. Was Deceder If Yes, specify 1 ☐ Yas 2 ☐		Specify:	, Puèrto	Rican, etc.)		Bleck,	White, e	
per		15. Decedent's E	ducation		16e. D	ecedant's Usuel (Occupat	tion			16b. Kind	of Busi		
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Bec		a (First, Middla, Last	t)					18. Mothe	r's Neme	(First, Middle,	Meidan S	u <i>ma</i> me))	
0	CHARLES	S HADERMAN	N					ANN	A E.	POTTS				
-	19a. Informant's I	Name/Ralationship	(Type, Print)		19b. N	Mailing Address (Street e	nd Numbe	er or Rura	al Route Numbe	r, City or 1	Town, S	tata, Zip	Code)
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-	20e. Mathod of Di				Pleca of D	Disposition (Neme	of			Dete	20c. Loca	-		
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dicai Examiner	Sequentially list of eny, leeding to ceuse. Enter Unc Ceuse (Disease of the initieted ever resulting in deeth	conditions, immediate derlying or Injury its	b	Due to ((or as e co	nsequenca of):			Coa	CTOL)
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Medical	resulting in deeth	conditions, immediate derlying or Injury its	b	Due to ((or as e co	nsequenca of): nsequenca of): nsequenca of):				•	obacco us	ae contr	ribute to	the cause of death?
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Registrar



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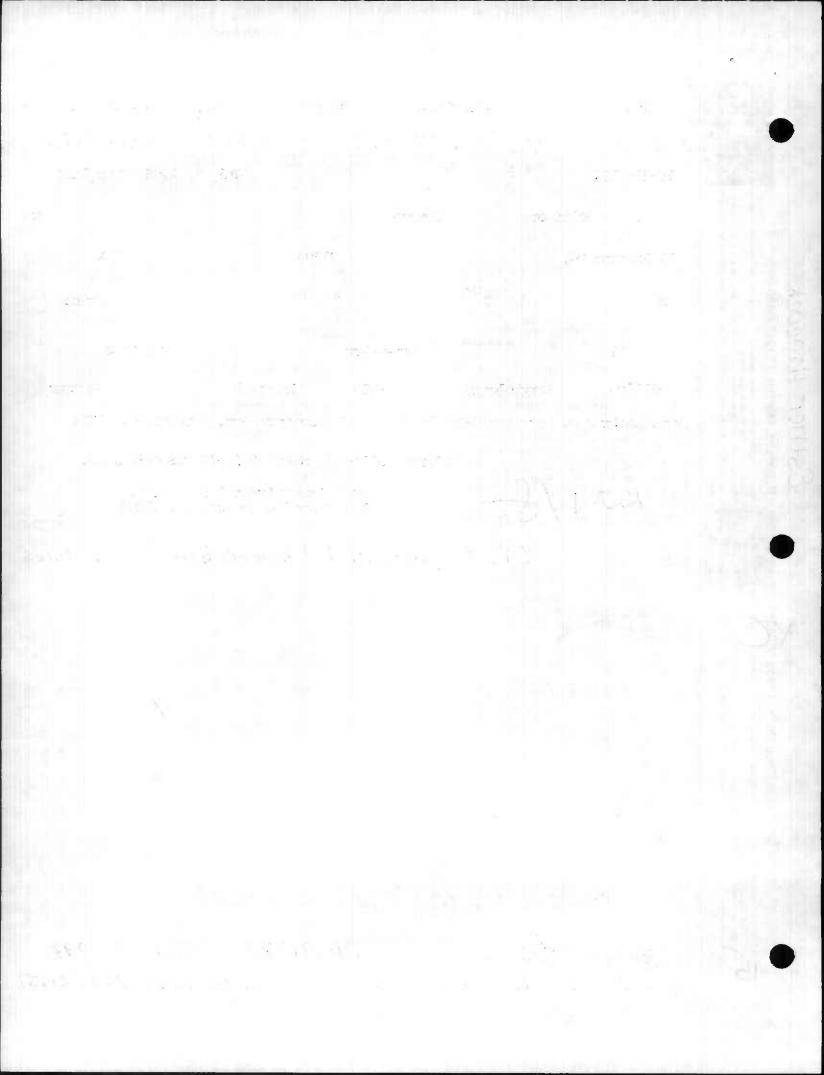
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Esther Elizabeth Hancock /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a_Facility Name (If not institution, give street and number) Examiner 09 5. Social Security Number If Under 24 Hrs if Under 1 Year Birthplece (Stete or Foreign Country) (In vrs. last birthday) **Funeral** 92 Months Davs Hours 1□ M 25 F July 10 1906 Maryland Director 219-28-9184 Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inalde City Limits "natural", or itema 23a or 28a-f ahow edical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Towson Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number with 17 Aintree Rd. 21204 TISA Funeral death Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - Amarlcen Indian 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 ☐ Yas 2 ☑ No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumatic avent, the Medical 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) and Mental William Bartholemay Kalb Elizabeth Seymour 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) contant: If Item 27 is injury or other tre 957 Fairmount Ave. Towson, MD. 21204 Mrs. Kathryn W. Corrigan/G-Daughter 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition o 1 Burial 2 □ Cramation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7-16-98 Dulaney Valley Cemetery Timonium, MD. 22. Nama and Address of Facility 21. Signature of Funeral Sarvice Licenses Ruck Towson Funeral Home, Inc. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death 23e. Pert1. Enter the disease, or comshock, or heart failure. List only **Physician** tempor oparieTAl hemorrhage Immediate Cause (Finel diseese or condition resulting in death) /Medical 6 HOURS Examiner Due to (or as a consequence of): Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 88 986 Division of Vital Records, P.O. Box 23b. Did tobacco use contributs to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 2X No 3 Probably 4 Unknown 1 Yes à 24b. Wara autopsy findings available prior to should I 24e. Was an autopsy Completed completion of causa of death? page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Dey Yeer) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After t Certification: 1 Neturel
2 Accident Hospital or Attanding 5 Pending Investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) in 24 hour.

The Funeral Dire.

Tilled in by 4 Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Data signad (Month, Day, Year) 29c. License number 29b. Signature and title of certified untolla De 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Square DR. BALTIMORE, Md. 21237 9000 FRANKlin BREWSTER D,0, Keuin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Salia Varidson Bandala

Registrar **DHMH 16 Rev 6/95**

Sther Hancoel

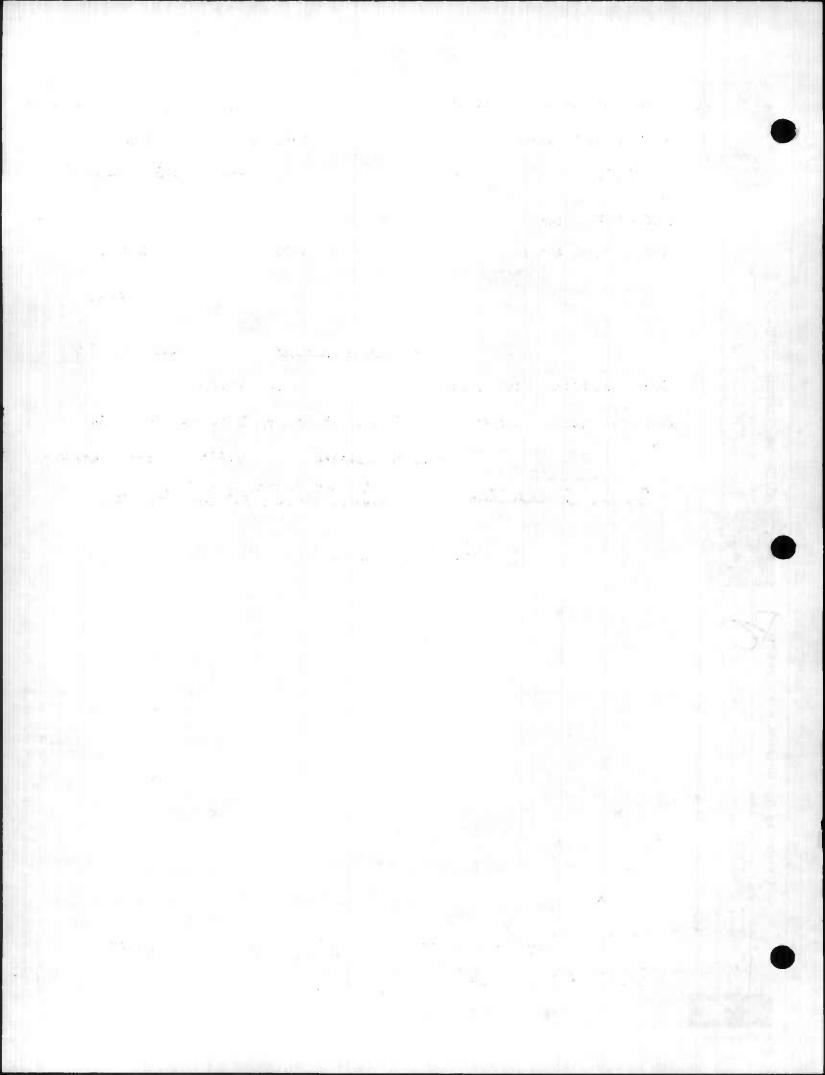


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State of Maryland / Department of Health and Mental Hygiene 8 2 | 6 9 4

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To the Hospital or Att within 24 hours efter di To the Funeral Direct completely filled in by t

30. Neme and eddress of person who completed cause of deeth (item 23a) (Type, Print) Stephen Radentz, M.D.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

JULY 11, 1998

29c. Licensa number

O.C.M.E.

31. Dete filed (Month, Day, Year) State Registrar

29b. Signature and title of cartifier

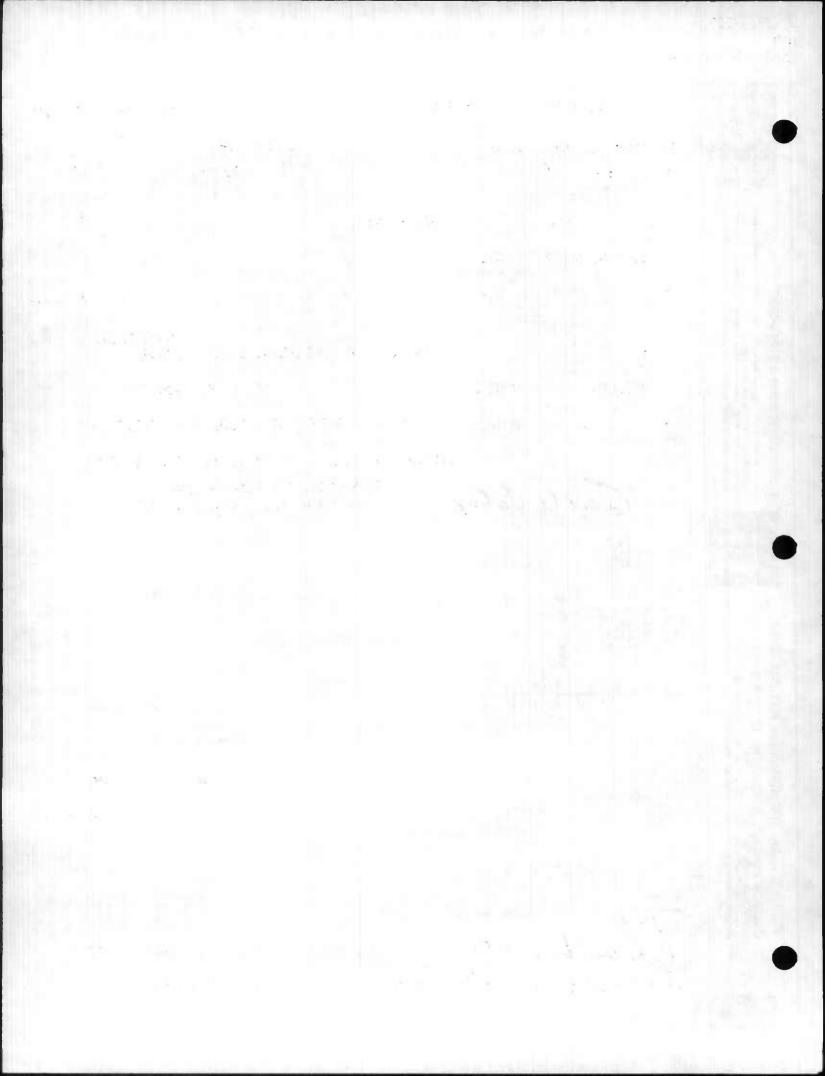
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aminer	4a Fa	cility Nama (/	If not institution, g	ive street end numbe	r)			4	b. City, Town, or L	or Location of Death 4c. County of Death					
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Maryland 21215-0020 d 2 should be filed within 72 hours after dea th and Mental Hygiena. 7 la marked other than "natural", or flems traumatic event, the Medical Examination To Be Completed by Funer	#□ Never Married 2 Married 3 Widowed 4 Divorcad			Armed Force 1 Yes 2# If Yes, Give	1 Tyes 24 No		- 44	s Decedent of Hispanic Origin? (Specify es, specify Cuban, Mexican, Puerto Rical Yes #1 No Specify:			rto Rican, atc.) Black, White			o AMERICAN	
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any injury or DDGB.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME								Α.						
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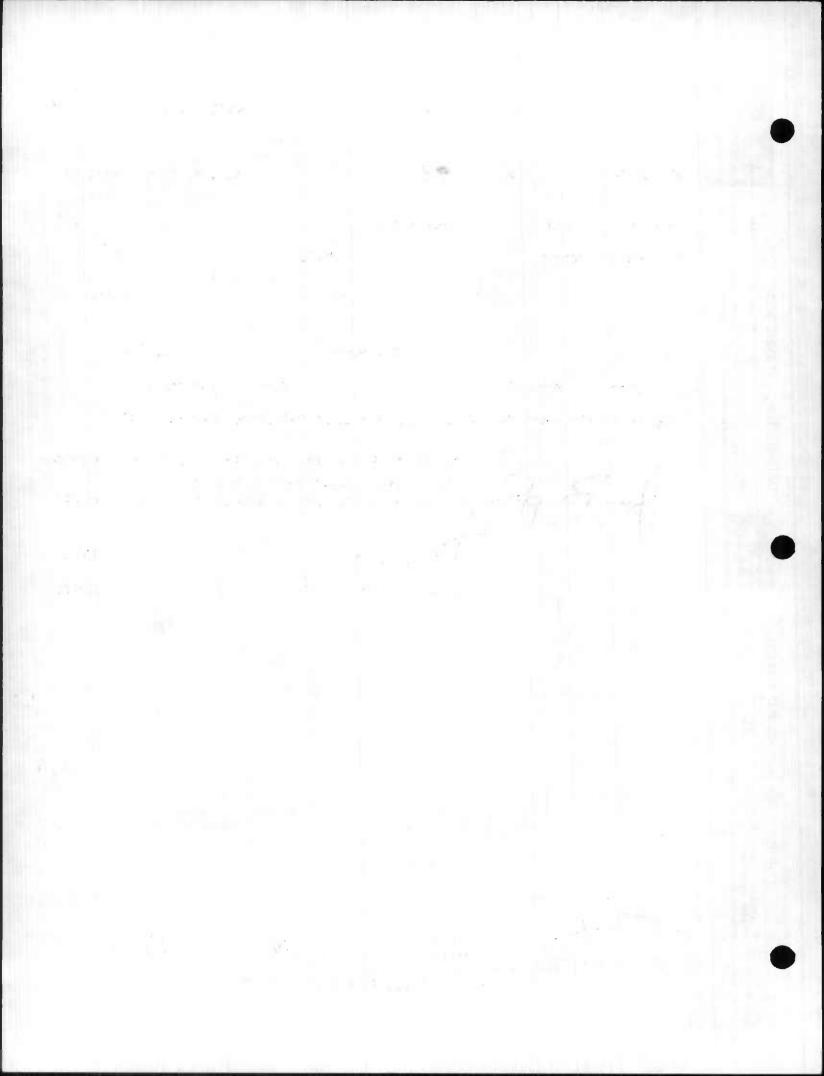


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth 3. Time of Death **Physician** July 13, Gertrude Kraft 1998 7:00 PM Mary /Medical 4b. City. Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Genisis Eldercare Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 □ F Yrs 213 52 2404 Director Aug. 4, 1905 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marylar 1 Yes 2 No r 28a-f s Directo Maryland n/a **Baltimore** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be r 21223 USA 1935 Lemmon Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. permit. Pages 1 and 2 ahould be filled within 72 hours after of Department of Health and Mental Hygiens. Introportant: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specity: Specify: White þ 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 **Housewife** Own Home 18. Mother's Name (First, Middla, Maidan Surname) 17. Fether's Name (First, Middla, Last) Be John Norwood Mary (unknown) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 3 Bogby Court Baltimore, Maryland 21220 Stephen Philip Smith (Grandson) 20b. Place of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 7/16/1998 Loudon Park Cemetery Baltimore. Maryland ture of Fun Star Service Licens 21. Si 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate interval Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examine Examiner senile The law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 98 080 signed by the a 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to completion of ceuse of death? should s 24a. Was an autopsy Completed of death? is certificate has director, page 2 1 Tyes 2 No Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Tyes 28 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🛍 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year) 286. Signature as time 29c. License number Mechanil 9 Attendina 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 4000 Old Court ld # 203 Bathmore 4d 21208 Schwartz M.D 1998 32. Registrar's Signature State wa Daydson Randelle Registrar

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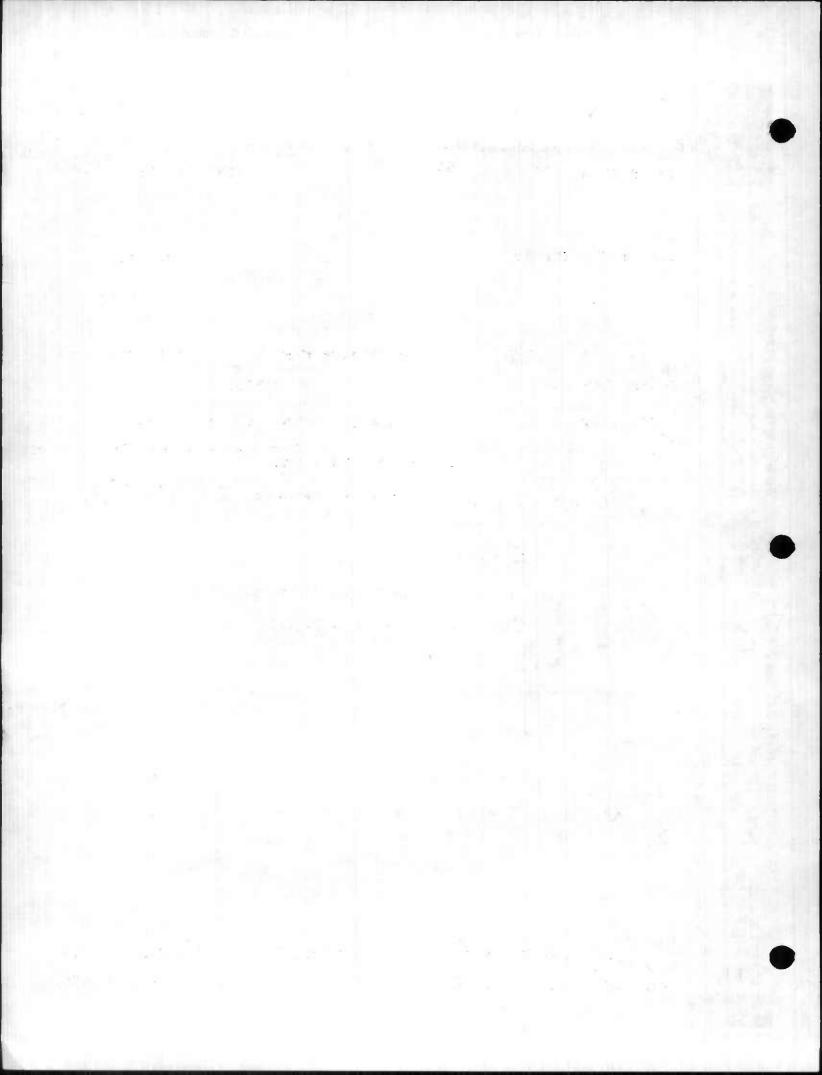
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9 8:06 pm Jul 1998 LZWSDO Zimes · /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) MAY 21,] BA Itimore Veterais Administration Medical Centa B4 Himore 7. Age (In yrs. last birthday) 65 yrs. Birthplece (Stete or Foreign Country) 5. Sociel Security Number 10XM 2□ F Months Deys 216-28-2714 1933 ŃC Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD 1 X Yes 2 □ No N/A BALTO Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3314 INGLESIDE AVE 21215 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Marital Status 2 should be filed within 72 hours efter end Mental Hygiene. Is marked other than "natural", or ite ty Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specif BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) 10th MAINTANCE MAN APT. COMPLEX 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JOSEPH LAWSON GAYDOLIA WOODAY 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rure! Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 sh Department of Health end Important: If Item 27 is m eny Injury or other traun pnce. LUCY WHITERS 3314 INGLESIDE AVE BALTO, MD 21215 20b. Place of Disposition (Name of cametery, cremetory or other place) CEM 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion ☐ Other (Specify) 7-16-98 OWINGS MILLS, MD GARRISON FOREST VA 22. Name end Address of Fecility BETTS FUNERAL HOME 23a Pert . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart feilure. List only one cause on each line. 1129 N. CAROLINE ST BALTO, MD 21213 **Physician** Immediete Cause (Finel diseese or condition resulting in deeth) /Medicai a. Esophageal (an Due to (or es e consequence of): Examiner Physician/Medical Examiner Tracheoes ophage al Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Bind Chemical USB 23h. Did tohacco use contribute to the cause of death? Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Cunknown À 8 24b. Were eutopsy findings evallable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed hes 1 Yes 2 No 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 10 this 28a. Dete of injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: After or Attending 5 Pending 1 Neturel 2 Accident after death. 1 Tes 2 No investigetion 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a Funeral D Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical (Check only To the Vithin 2 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifler 29c. License number P10522 30. Name end eddress of person who completed cause of death from 23e) (Type, Print)

State

31. Date tiled (Month, Dey, Year) JUL 151998 Registrar

GreeneStreet BAltimore, MP 21201 S, ATTHY Herrander 32. Registrer's Signature

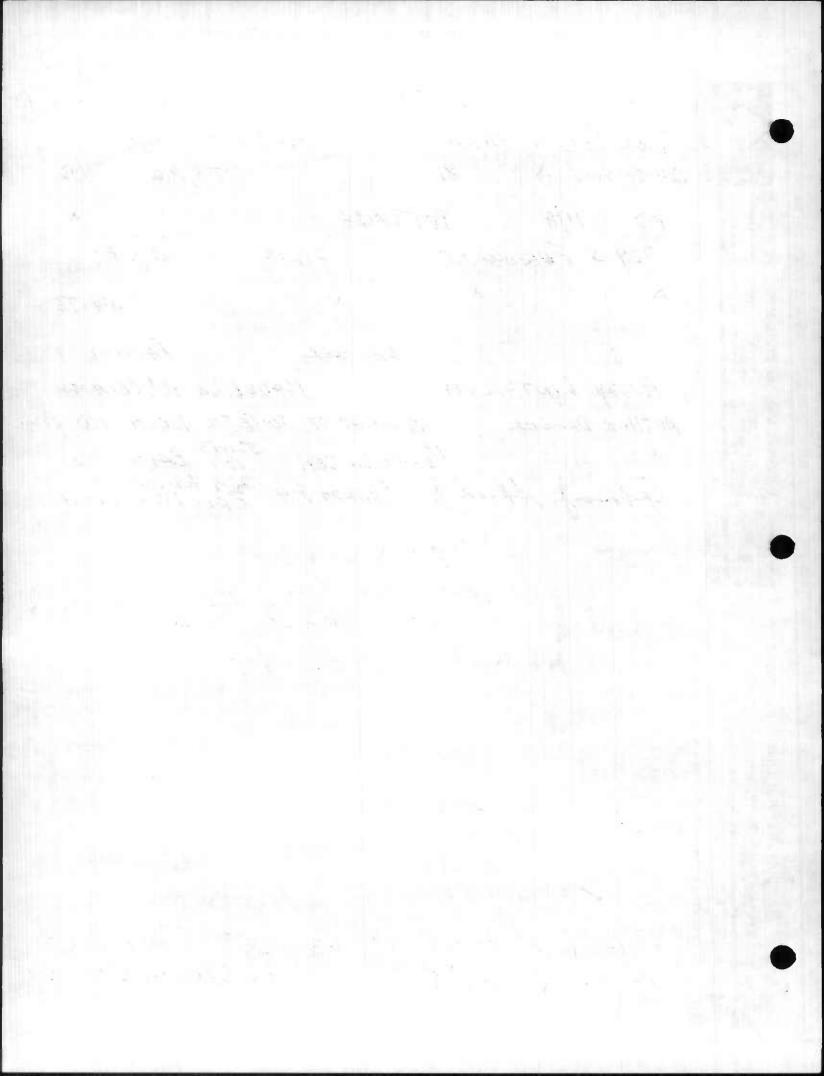


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IF Undar 24 Hrs. 8. Data of ON UR If Undar 1 Yaar 6. Sex 10 M 2□ F 7. Age (In yrs. last birthday) Yrs. 8. Data of Birth 9. Birthplace (Stata or Foraign Country) 5. Social Security Number **Funeral** Min. Months Days 214-70-9405 Usual Rasidance of Decedant Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland net of Health and Mental Hygiene.
Instit of Health and Mental Hygiene.
Instit from 27 Is marked other than "natural", or items 23a or 28a-f show mit: if item 27 Is marked other than "natural", or items 23a or 28a-f show inty or other traumatic event, in Medical Express matter and the nourised at 10c. City, Town or Location 10s State 10b. County 10d. Insida City Limits 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 309 U.S.A RROW 57 21223 Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 D No if Yas, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 Navar Marriad 2 Married 1□ Yas 2 No Specify: PV 3 □ Widowed 4 □ Divorced WHITE Completed 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamantary/Secondary (0-12) Collega (1-4or 5+) LABOKER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Nama/Ralationship (Type, Print) SUITE 510 MO. 21202 DRAGER BALTO. ARTHUR 1614 20b. Place of Disposition (Nama of capitatary, cramatory or other) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata
4 Donation 5 Other (Specify) permit. Pages Department of Important: If it any Injury or o 21. Signature of Funaral Sarvica Micanses 22 Name and Address of Facility 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Daath **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner to (or as a consequence of): Examiner arterio sele physician and the buriel-transit the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequance of): 88 for use as acu signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 thiknown þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed complation of cause certificate hes b 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No Attending Physician: 25. Was casa rafarrad to medical axaminar?
1 ☐ Yas 2 ☐ No Be 26. Placa of Daath (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 2 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funerel 28a. Data of Injury (Month, Day Year) 27. Mannar of Daath 28d. Dascribe how injury occurred 28b. Time of Certification: 28c. Injury at Work? After 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No death. 2 Accidant eftar deatl 6 Could not be datarmined 3 Suicida Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 0 24 hours e Hospital 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medical To the Hosp within 24 ho To the Fune completely f 29d. Data signed (Month, Day, Yaar) 29b. Signatura and titla of certifier 29c. Licansa number 121-1

State Registrar 31. Data filad (Month, Day, Yaar)

30. Name and addrass of person who complated causa of daath (Itam 23a) (Typa, Print)



Be Completed by Funeral Director

70

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

Death Medical Control

32 Segistrary Signature
July Davidson-Hands

31. Data filed (Month, Dey, Year)

JUL 151998

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axa <i>m</i> inar? 1 ☐ Yas 2 ⊡ 1		Hospital:	nt 2 ER	/Outpatient 3	3□ DOA	Other:	Homa 5 Rasio		ar (Specify)	
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(Check only	1 Certifying Ph	niner: On the besis of	axamination	dge, death occ	curred at	the time, date and plec my opinion, death occ	e, and due to the urred et tha tima,	causa(s) and ma	innar as stated.	euse(s)
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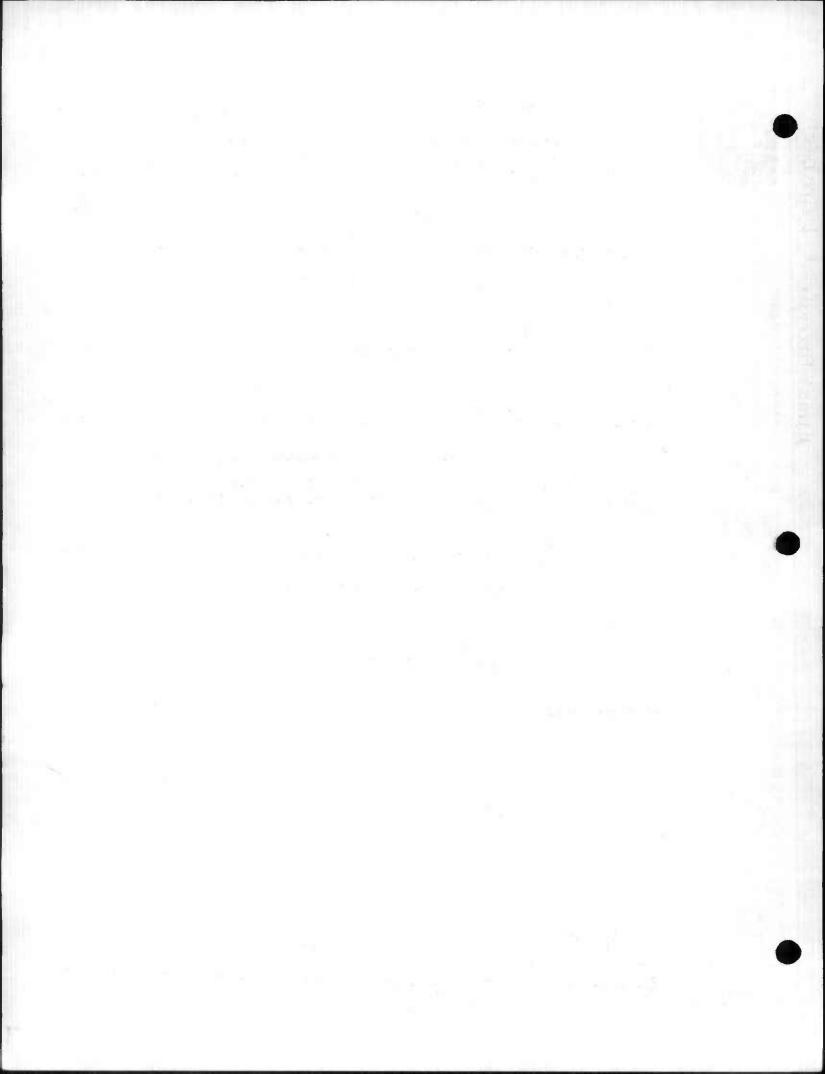
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Balkimme mp

21230

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Deeth Month LINDA Morris JOAN July 0155 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street end number) 4c. County of Deeth GEN HOSPISAL FALLSTON FALLSTON HAZEOUS 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. (Month, Dey, Year) 5. Sociel Security Number Birthplece (State or Foreign Country) 1 ☐ M 2 👿 F 212-50-2197 49 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Abingdon 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3328 S. Berlin Court U.S.A. 21009 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck. White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 years Parts Purchasing Agent Tractor Equipment Co. 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Louis William Rehberger Mary Margaret Drury 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3328 South Berlin Court, Abingdon, MD. John R. Morris (Husband) 21009 20e. Method of Disposition 20b. Piece of Disposition (Neme of cametery, crematory or other pleca) 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 Ø Other (Specify) Entombment Bel Air Memorial Gardens 7/13/98 Bel Air Maryland 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21 21014 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth immediate Cause (Final disease or condition resulting in death) Mulkplo Mycloma. Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequenca of): Due to (or es e consequença of) Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 254No 25. Was case referred to medical

Physician /Medical Examiner

permit. Pages 1 and 2 Department of Haelth a Important: If Item 27 is any Injury or other trai

Physician

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Director

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items 23a

Pages 1 and 2 should be filed within 72 hours after deeth nant of Haalth and Mental Hygiena. Int: If Item 27 is marked other than "natural", or Itema 23.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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with the Manyland

signed by the a The law requires that the

Physician/Medical Completed by Aftar this cartificete Be Lo Certification:

Box 68760

Division of Vital Records, P.O. or Attending Physician: daath. after death illed in by tha • Funeral C Hospital

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State Registrar

edical

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) GPNASHO M.D 31. Dete tiled (Month

5 Pending Investigation

6 ☐ Could not be determined

YOYes 2□ No

27. Menner of Death

1 Naturel

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

D mo

28a. Dete of injury (Month, Dev Year)

NA

32. Redistrer's Signeture

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA

28b. Time of

28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

injury

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29c. License number

OCME

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. injury et Work?

1 ☐ Yes 2 No

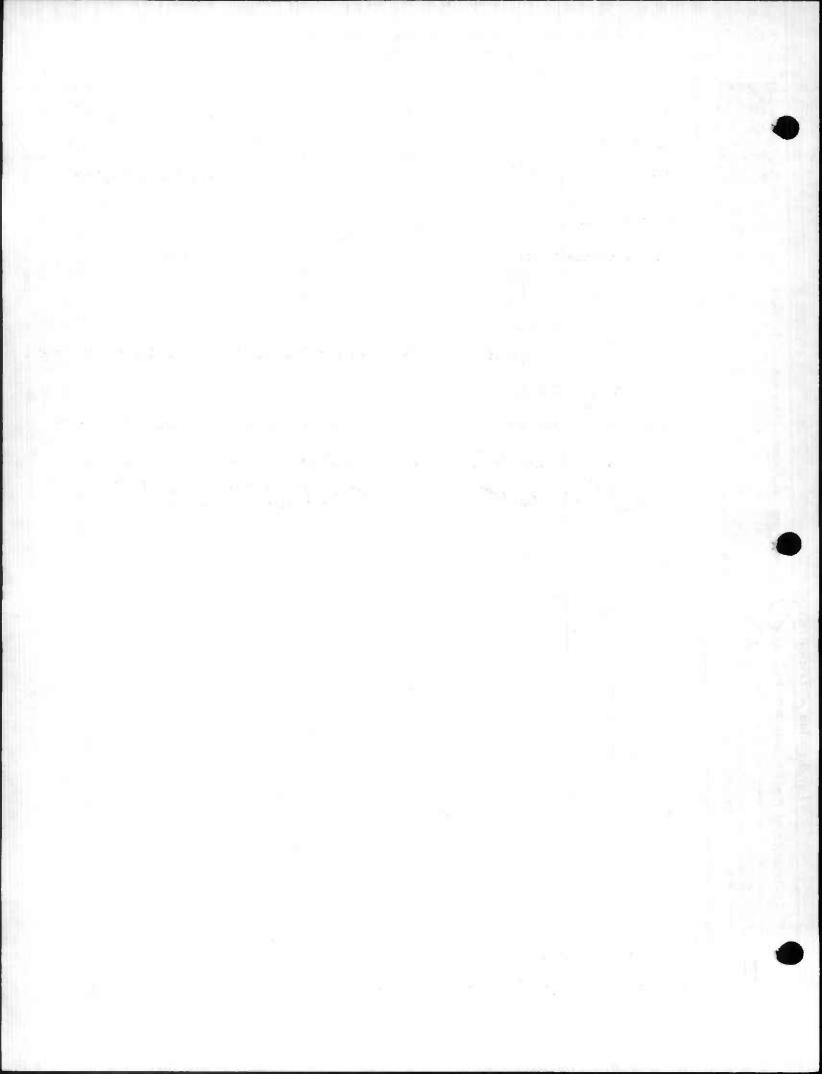
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated.

29d. Dete signed (Month, Day, Year)

218 FULFORD ANE BELAIN MD 21014

within 2 To the ÷



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 12 NOON Buster MMIE 4b. City, Town, or Location of Deat 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Anenue Daltimore 307 1deron If Undar 1 Yaar] If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) 5. Social Sacurity Number 6. Sax 100 M 20 F 87 Months Days Hours Min Yrs. 231-09-9956 Usuai Rasidance of Decedant Va 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location Baltimore NA 1 Yas 2 No Ma 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Armed Forcas? 12. Was Decadent Evar in U.S. Armed Forcas? 1 \(\) Yas 2 \(\) No If Yas, Giva Yaar or Datas: U.SA 4307 2/2/5 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Maritai Status Biack, Whita, atc 1 Navar Marriad 2 Married Specify: Black 1□ Yas 2 No Spacify 3 XWidowed 4 □ Divorcad 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. ,OO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Bethlehem Elementery/Secondary (0-12) College (1-4or 5+) abore Unknow Unknown 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) 1at Martin nknown 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Raiationship (Type, Print) Shinley 4307 Bathmore, Ma denon Daughter 20b. Piaca of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from Stata Memorial 7-15-98 Kandallstown, rd 4 Donation 5 DOthar (Specify) 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvica Licansee F. H. West 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. land Guenne Approximete Intarval Batween Onsat and Daath Immediata Causa (Final disaasa or condition rasulting in daeth) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 € Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy performad? complation of causa of deeth? 2 X No 1 Yas 2 No

Physician /Medical Examiner physician and the burial-transit The law requires that the death certificate be executed

Examiner

Physician/Medical

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Physician

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Department of Health reportant: If Item 27

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Pages 1 and 2

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Director

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Completed

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The Maryland

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initieted avents rasulting in death) Last

1 Yas

26. Place of Deeth (Check only ona)

25.	Was casa rafari axaminar?	ed to medical
	1 Yes 2 7	
27.	Mannar of Death	1
	1 Natural	5 Pandin
	2 Accident	investig

5 Panding investigation

6 Could not ba

Hospital:

28a. Data of Injury (Month, Day Year)

1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 Yas 2 No

Other: 4 Nursing Homa 5 Desidance 6 Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta)

29a. Cartifian (Check only one)

3 ☐ Suicida

4 Homicida

1 💯 Certifying Physician: To tha best of my knowladga, daath occurrad at tha tima, deta and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

29b. Signature and titia of cartifle

lucu

28a. Piaca of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

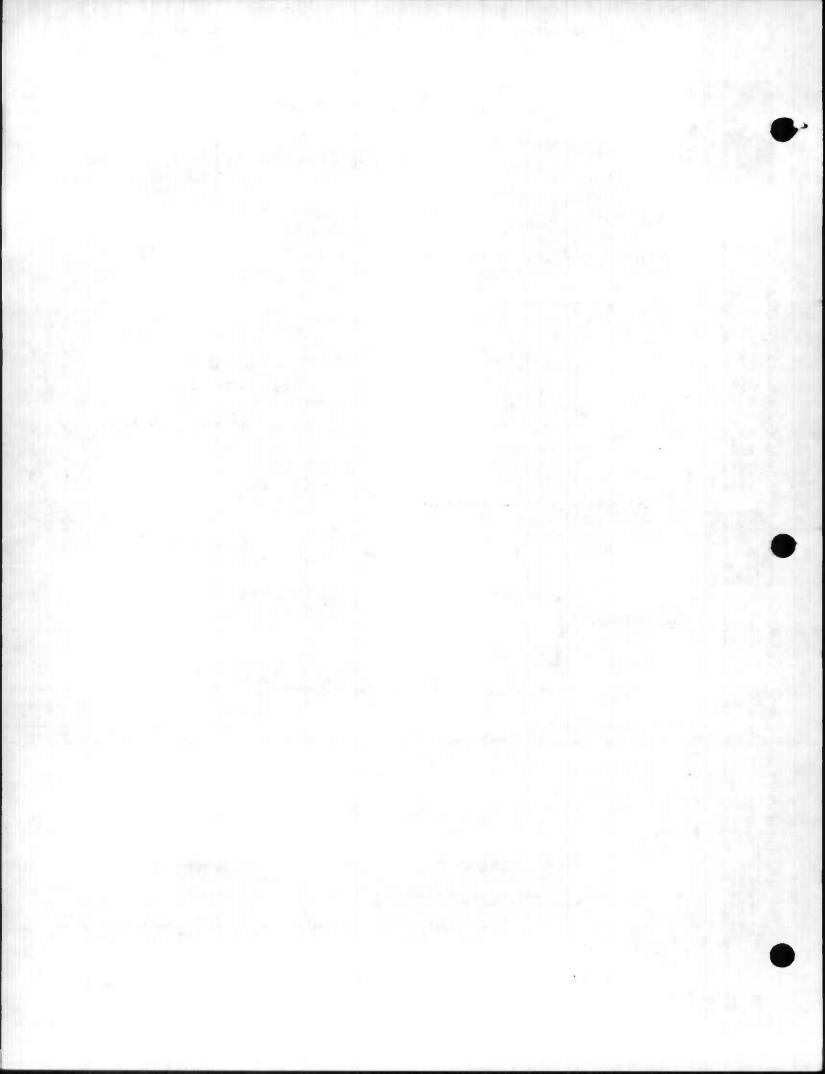
29c. Licansa number 3066 29d. Data signed (Month, Day Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 51 REESH 501 200h Raw BLW, Baltimerter TRIF Baltimole. n, Day, Year) JUL 15 1998 31. Data filad (Month,

State Registra

32. Regis are Signaura

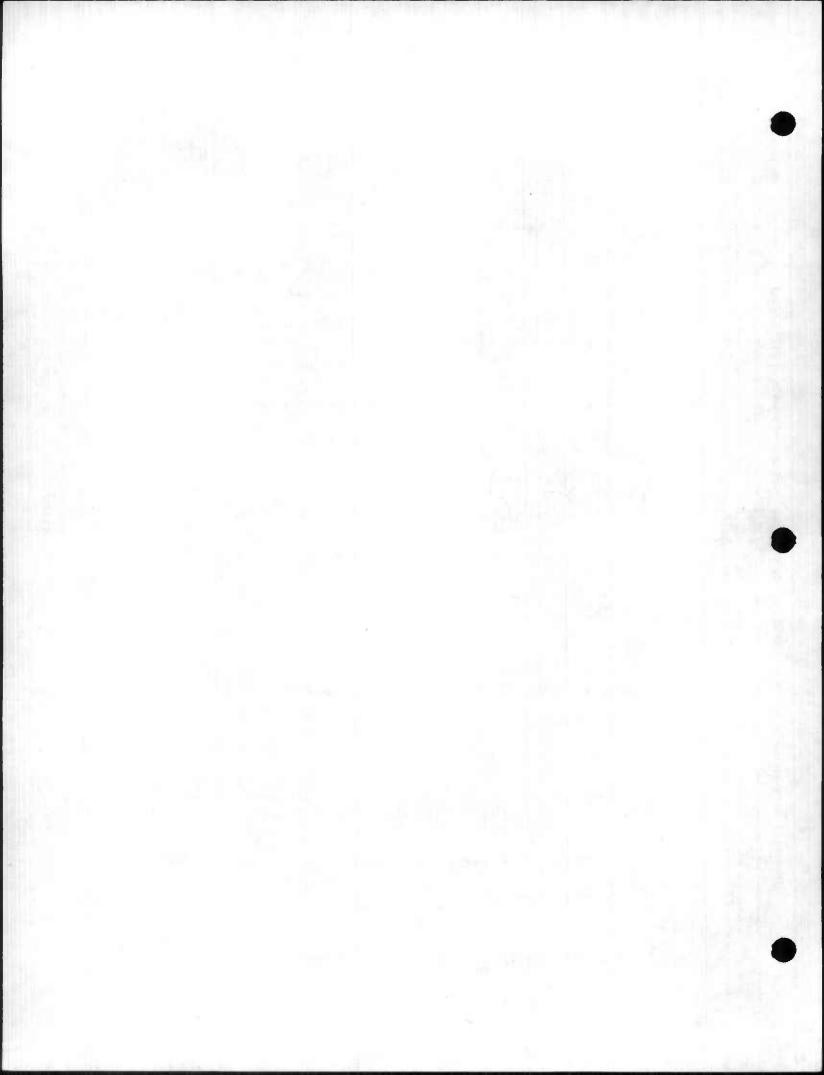
Fuha Daydson - Randall



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

	Certificate of De	eath Reg	, No.
vsician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Time of Death
dical	Bertha R. Milling	July 14	
ner	4a Facility Name (If not institution, give street and number) 4b. C	City, Town, or Location of Death	4c. County of Death
ral or	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) ff Under 1 Year ff Under	Under 24 Hrs. 8. Date of Birth Jours Min. (Month, Day, Y	ANNE ARUNDEL 9. Birthplace (State or Foreign Country) 1922 MISSISSIPPI
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Director	MARYLAND ANNE ARUNDEL PASADENA		1 □ Yes 2 □XNo
Pie	10e. Street and Number 10f. Zip Code	100	. Citizen of What Country?
	2309 230th STREET 2112		U.S.A.
by Funeral	1 Never Married 2 Merried 1 Yes 2 No	nic Origin? (Specify Yes or No- lexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
pete	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during	n 16	Sb. Kind of Business/Industry
Completed	(Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 (Give kind of work done during life. DO NOT use retired) HOMEMAKER		HOUSEHOLD
Bec		. Mother's Name (First, Middle, Ma	
To B	BERNARD SASADA	DOROTHY	BORKOWSKA
-	19a. Informant's Neme/Reletionship (Type, Print) . 19b. Melling Address (Street and I	Number or Rural Route Number, (
	Cathyrae McNamara daughter 2309 230th Stre	et Pasadena, MD	21122
	20a. Method of Disposition 20b. Place of Disposition (Name of camelery, crematory or other place)	Date 20	c. Location - City or Town, State
	1 Burial 2 Cremelion 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY INC	7/15/98 B	ALTIMORE MARYLAND
ance		FRAL HOME P.A. Road Pasadena, uch as cardiac or respiratory arres	Maryland 21122 t, Approximate Interval Between Onset and Death
Je.	Immediate Cause (Finel disease or condition resulting in death) a. Congestive Heart F. Due to (or as a consequence of):	aune	3yrs
- Le	I DDM		710yrs
Examiner	Sequentially list conditions, if any, leeding to immediate		5urs
	if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	5	JULZ
Medical	Due to (or as a consequence of): d. HTV		>10405
clar		1	
Physician/	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part t. 23b. Did tob	scco use contribute to the cause of death? No 3 Probably 4 Unknown
eted by		24a. Was an performe	ed? available prior to completion of cause
Completed		1 ☐ Yes	of deeth?
Be	'25. Was case referred to medical examiner?	6. Place of Death (Check only one)	
2	1 Yes 20 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:	4 Nursing Home 5 ☐ Residen	ce 6 □Other (Specify)
	27. Manner of Death 1 Statural 5 Pending (Month, Dey Year) 20 Accident investigation 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work? 1 Yes	28d. Describe how 2 □ No	injury occurred
Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, described in the control of t	date and place, and due to the cau on, death occurred at the time, date	use(s) and manner as stated. e and place, and due to the cause(s)
N S	29b. Signature and title of certifier 29c. License nur	imber 290	d. Date signed (Month, Day, Year)
	Onumero D38 5	sale !	7/13/98
State	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (200 Bid aley QVC 5 L20 Anna 00115) 31. Date filed (Month, Q4) (Year) 5 1000 32. Registral significant	mo 21401	

DHMH 16 Ray 6/95



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State of Mary	land / Department of Health and	Mental Hygiene	18 2	17	04
	Certificate of Death	Reg. No.			
ast)		2. Date of Death	Vans	3. Tim	e of De

Physician /Medical Examiner

4a Facility Name (If not institution, give street and number

10d. Inside City Limits

Approximata Interval Between Onset and Death

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1□ Yas 2□No

Funeral Director

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r than "natural", or frams 23a or 28a-f ahov al Hygiena. 1 and 2 should be fill Heelth end Mental H em 27 la marked ott end N permit. Pages 1 and 2 Department of Heelth e Important: If Item 27 Is

altimore, Maryland 21215-0020

Physician /Medical Examiner

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Physician/Medical

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Certification:

Medical

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sician end 4 88 USB 0 detached 8 page 2 certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

requires that the death certificate be execu

Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, L NORman S. Miller Sp. July
and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Mercy Medical Center If Under 1 Year 8. Date of Birth (Month, Day, Yeer) Aug 23, 1915 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 10 M 20 F Days Hours Min Yes Maryland 82 213 03 1470 Usual Rasidence of Decedent 10a, State 10b. County 10c. City, Town or Location Maryland Baltimore ESSEX 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 USA 1125 Engleberth Road 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - Amarican Indian, Black, White, etc. 11 Marital Status 1X Yes 2 No If Yes, Give Year or Dates: WW2 1 Never Married Married Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry Elementary/Secondary (0-12) College (1-4or 5+) Continental Can Co. Sheet Metal Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Samuel Miller Mammie Matthews 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 1125 Engleberth Road Essex, Maryland 21221 Gloria A. Lonscak (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burlal 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) Joseph's Fullerton Cem 7/16/98Balto. County, Md. of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 ations that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, acquise on each line. Myelodys plasiA Immediate Ceuse (Final disaasa or condition resulting in deeth) Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contributs to the cause of death?

Preminia, Reval for lure 1 Yes 2 No 3 Probably 4 Unknown

hypothy roidism

6 Could not be determined

24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy

25. Was cese referred to medical examiner? 1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

1 ☐ Yes 2 ☐ No

27. Menner of Death 1 Neturel 2 Accident 5 Pending investigation

28c. Injury at Work? 1 Yas 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier

31. Date filed (Moi

3 Suicide

4 Homleide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es stated.
2 Medicat Examinar: On the best of axamination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner statad.

29b. Signature and title of certified

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29d. Data signed (Month, Dav. Year)

30. Name endjeddress of person who completed cause of deeth (Item 23a) (Type, Print)

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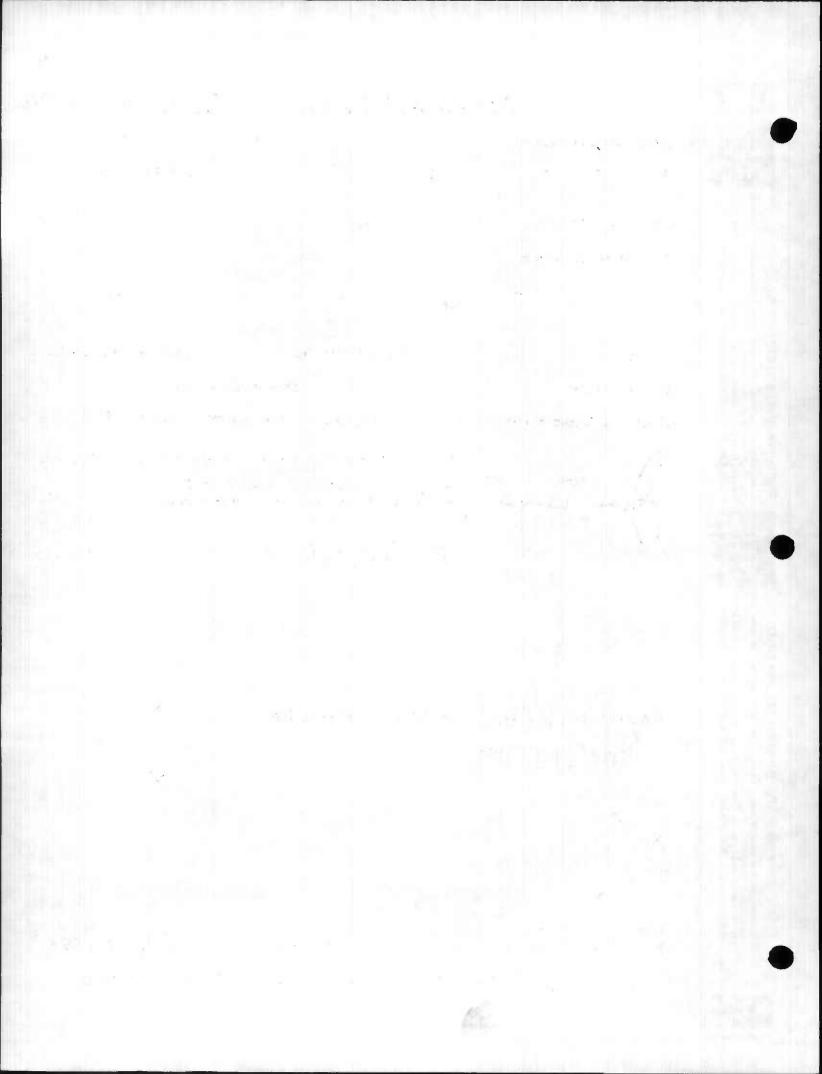
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It Paul MACe Baltinice

State Registrar

32. Registrar's Signatura ia Devidson-Randoll

within 2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 4:46 A.M Marlene G. Mahan 1998 4c. County of Death July 13, ation of Deeth /Medical 4b. City, Town, or Location of 4a Fecility Neme (If not institution, give street end number) Examiner Glen Burnie Anne Arundel North Arundel Hospital 8. Date of Birth April 12, 9. Birthplaca (State or Foreign Country) Maryland 7. Age (In yrs. last birthdey) 56 Yrs. If Under 1 Year 5. Sociel Security Number **Funeral** 1 M 2 X F Months Days Hours Min. 1942 Director 217-38-8238 Usual Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Directo Md. N/A ž 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "netural", or items 23s or Medical Examiner must be. 4007 Third Street Funeral 21225 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after Department of Health and Mental Hygiens. Important: if Item 27 is merked other than "natural", or ite any injury or other traumetic event, the Medical Examina. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□Yes 2√∏No Specify by White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) My Brother's Tavern 9th Barmaid 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Meredith Н. Lewis Vida Loretta Garner 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4007 Third Street Balto., Md. 21225 Tina Mahan (Daughter) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 N Burlel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 7/16/98 Baltimore, Maryland 22. Name end Address of Facility
McCully-Polyniak Funeral Home 21. Signature of Funeral Servica Licensee Kevin E. Ecker 237 E. Patapsco Ave., Balto., shock, or heart failure. List only one cause on each line. Md. 21225 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner physician end the burial-trensit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): attending p 88 signed by the a 23b. Did tobacco usa contribute to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25 No 3 Probably 4 Unknown 1 Yea þ 24b. Were eutopsy findings available prior to completion of cause of death? should I Completed 24a. Was an autopsy certificate has b lirector, page 2 s 1 Yes 2 No 1 Tyes 2 No I or Attending Physician; after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 10 me 5 Residenca 6 Other (1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐Other (Specify) this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Dev Year) Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: / completely filled in by the 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specity) 4 | Homicide Hospital 29a. Certifier (Check only one) Medical To the Vithin 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mar DR. G (enter

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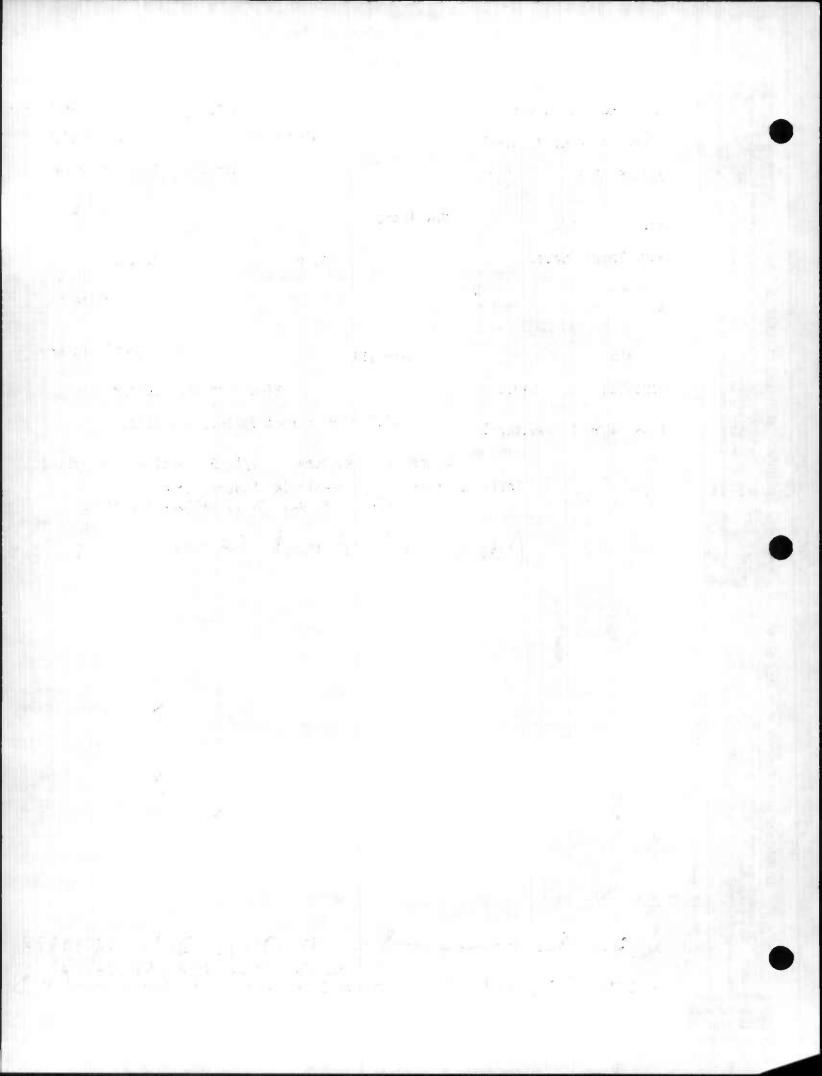
Registrar's Signature who Davidson Randalle S. -

Registrar

Das

JUL 1 5 1998

31. Date filed (Month, Dey, Year)



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			, many taria	Certificate of	Death	Reg. I	No. 98	21706
Physician /Medica	Maxir	Middle, Last) Louise	McEl	hiney		2. Dete of Deeth Month	Dey 1998	3. Tima of Death 8:52a
Examine Funeral Director	4 100 4.4	FRUNDEL	HOSP Age (In yrs. last b	inthday) If Under 1 Year Yrs. Months Deys		ocation of Death ULN/E 8. Date of Birth (Month, Day, Ye JULY 28	4c. County of Dec A.A. 9. Bi 1932	ath Co irthplece (State or Foreig BALTO., MD
how	Usual Residence of Decede 10a. Stete 10b. Co		10c. City, Too	vn or Location				10d. inside City Limits
Ay	MD ANN	E ARUNDEL	GI	EN BURNIE				1 ☐ Yas A☐ No
Q 6 88	10e. Street and Number			10f. Zip Code		10g.	Citizen of Whet C	Jountry?
		E AVENUE		210			S.A.	
020	1628 FURNAC 11. Marital Status 1 Never Married 2 3 Widowed 4 Dive	1/14 . 01 4	es? X □ No	13. Was Decedent of If Yes, specify Cui		pecify Yes or No- o Rican, etc.)	Bleck, Wh	nericen Indien, nite, etc. WHITE
21215-0020 21215-0020 d within 72 hours al giene. The Medical Exam.	15. Dec (Specify only I Elementery/Secondary (0- 8TH GRADE	edent's Educetion ighest grade completed)		e. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	ipation e during most of work ed)	king 16b	. Kind of Busines	s/Industry
5 17	8TH GRADE	(1-4	54)	MEAT CUTTER		ME	EAT PACK	ING COMPANY
The self of the se	17. Father's Neme (First, Mi					ne (First, Middle, Meid	den Sumame)	
To your hand	19e. Informent's Name/Rele	tionship (Type, Print)	19	b. Mailing Address (Stree				, Zip Code)
Baltimore, M Baltimore, M Pages 1 and 2 Department of Health a reportant: If then 27 is not injury or other tra	20a, Method of Disposition	ACH (DAUGHTER)	20b. Plece cemet	66 ASBURY RO of Disposition (Neme of ery, cremetory or other plants) DWRIDGE MEMO	face)		21122 Location - City of	
Balti permit. Departm imports eny inju	21. Signature of Fundal So	vice Licensee	4	22. Name end Addi HUBBARD F	ress of Facility FUNERAL HO			21229
Physician (Market)		List only one cause on eed	ch line.	not enter the mode of dy	ying, such es cardiac	or respiratory errest,		Approximate interval Between Onset and Death
/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death)	a. S	Due to (or as a	CANDIA consequence of):	C JE	474		
5 0 0	Ceuse (Disease or injury that Initieted events resulting in deeth) Lest	6.	ro nor]	consequence of): Artery consequence of):	Vise Wise	ase		
death cer e attendir	Pert II. Other significent co	ditions contributing to deel	th but not resulting	in the underlying ceuse of	given in Part I.	23b. Did tobac	cco uea contribu	ite to the cause of death
P.O. het the d by th detache						1 Yes	2 No 3	Probably Unknow
						24a. Wes en e performed		b. Were autopsy findings eveileble prior to completion of ceuse of death?
Vital Rec						1 ☐ Yes	2 % No	1 □ Yes 2 No
of Vita Physician: this certific	1 Yes 2 No	Hospital: 1 ☐ ing	patient 2 ER/C	dipatient support	her: 4 ☐ Nursing H	ath (Check only one)		pecify)
		ending 28a. Date of (Month, vestigation	Injury 28b.	Time of Injury M 1	jury at Pork? □ Yes 2 □ No	28d. Describe how i	njury occurred	
Division Nor Attending I effer deeth. Director: Affer din by the fune.	3 Suicide 6 C 4 Homlcide		f Injury - At home, , etc. (Specify)	farm, street, factory, office	ө	28f. Location (Stree City or Town, S	t and Number or tete)	Rurel Route Number,

29e. Certifier

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) and manner as stated.

| Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated.

| Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. 29b. Signature and title of certifier

29c. License number 3 6 3 8 4

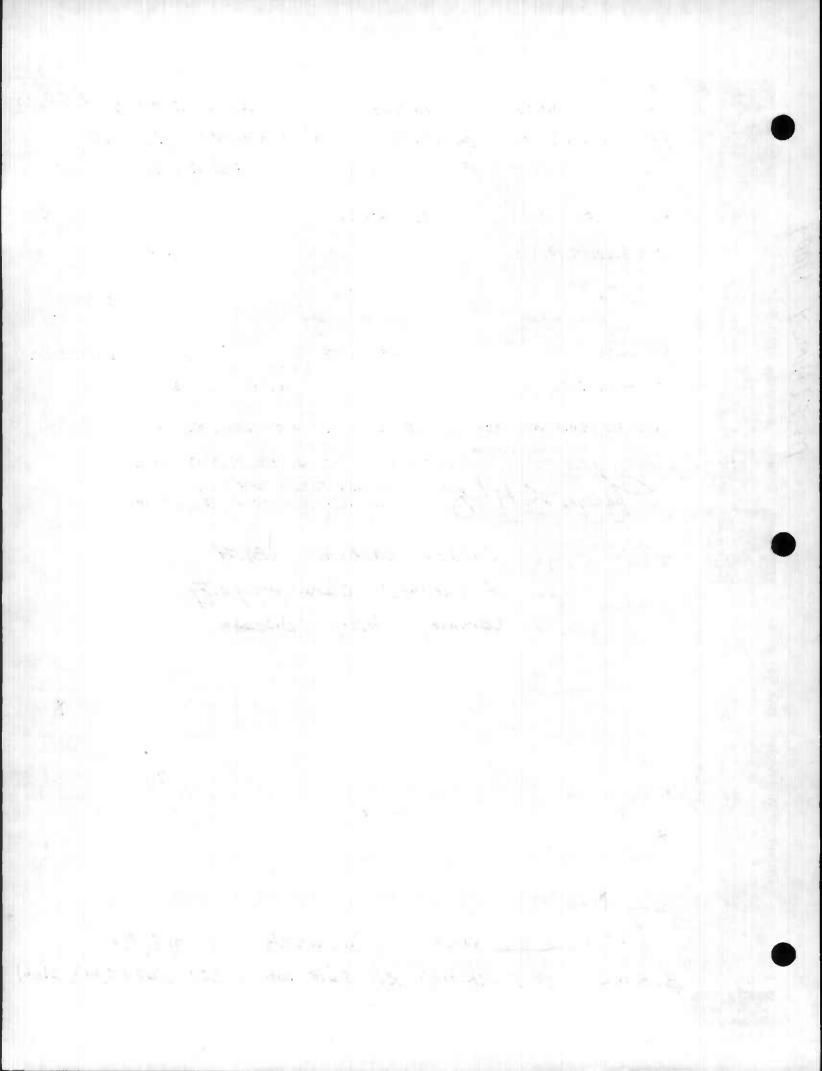
29d. Dete signed (Month, Dey, Year)

30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print) 8. BADRD 7815 AKWOOD Rd.

Suite 106, GLEN BURNIE HD. 21061

State Registrar

31. Date filed (Month, Day, Year) JUL 151998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

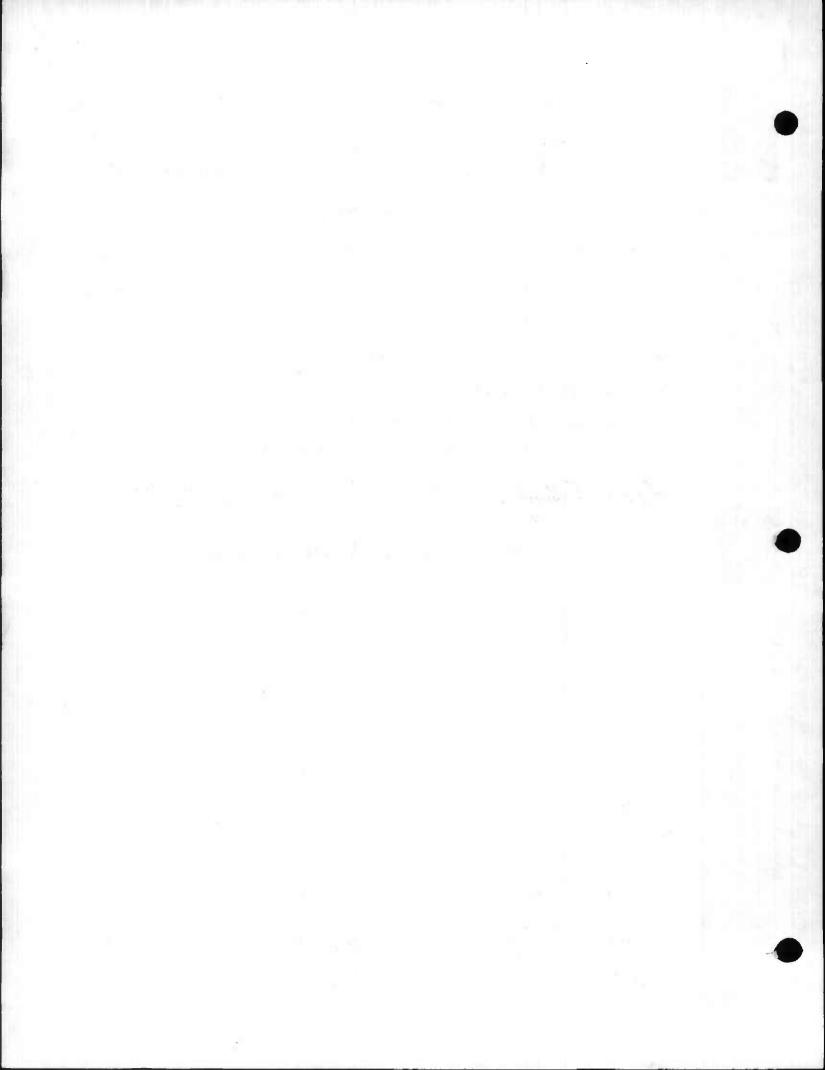
State of Maryland / Department of Health and Mental Hygiene 98

Maryland 21215-0020	Physici /Medic Examir Funeral Director				rtificate of	Doutin	F	Reg. No.	
Maryland 21215-0020	/Medic Examir Funeral		Decedent's Name (First, Middle, Last)				2. Dete of Dee		3. Time of Deeth
Maryland 21215-0020	Funeral			KINNEY			JULY 1	.0, 199	6:30 P.M
Maryland 21215-0020		ner	4e. Fecility Name (If not institution, give street end nun 2705 GATEHOUSE DRIV	E	1	4b. City, Town, or Le BALTIMOF		4c. County N/A	of Deeth
Maryland 2121			5. Social Security Number 6. Sex, 12 M 2 F Usual Residence of Decedent	7. Age (In yrs. lest birthday) 55 Yrs.	If Under 1 Year Months Days		8. Dete of Birth (Month, Pa) MAR . I	,1943	9. Birthpiece (State or Foreign Country) MARYLAND
Maryland 2121	la-f show	ctor	10e. Stete 10b. County N/A	10c. City, Town or Lo	cation LTIMORE				10d. Inside City Limits 1
Maryland 2121	23a or 28 sunt be no	Funeral Director	10e. Street and Number 2705 GATEHOUSE DRIVE		10f. Zip Code 21207			U.S. (
Maryland 2121	"natural", or items 23a or 28a-f show edical Examiner must be notified at	by	11. Merital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Wes Dece Armed From 1 □ Yes I'l Yes, Giv Year or Da	2 (2) No	Was Decadent of lift Yes, specify Cub. 1 ☐ Yes 2 ☐ No.	Hispenic Origin? (Spoen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		a - American Indien, kk, White, etc. · BLACK
Maryland	than	Completed	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1	4or 5+) (Give life. L	DO NOT use retire	during most of work	ing		isiness/Industry
	T S T	Be Co	N/A 17. Fether's Neme (First, Middle, Lest)	GR	OOM	18. Mother's Nem	e (First, Middle,	RACE Meiden Sumem	TRACK
	marked marked	ToB	JOHN MATTHEW Mc KIN 19e. Informent's Neme/Reletionship (Type, Print)		ng Address (Stree	JESSII t end Number or Run			KINNEY State, Zip Code)
0 - 3	Health er em 27 is other trau		PEGGY A. McKINNEY (USE DRIV			21207
			20e. Method of Disposition 1 □ Permovel from \$ □ Removel from \$ □ Donation 5 □ Other (Specify)		metory or other ple	PARK 7/1	Date	20c. Location -	ORE, MD. Co.
Balt Permit.	Department of Important: If i eny injury or once.		21. Signature of Funerel Service Licensee LEWIS			T. GWYNN	I FUNEI		
Phy	ysician ˈ		23a. Pert1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ex	used the death. Do not enter ich line.	4517 Pler the mode of dyi	ARK HEIC ing, such es cardiac	or respiretory en	rest,	ALTO, MD. Approximete Intervel Between Onset and Deeth
/N	Medical aminer		Immediate Ceuse (Finel disease or condition resulting In death)	Due to (or es e conseq		ell carc	PMONI		3 MONTHS.
penned	physician and s the bunel-transit	Examiner	Sequentially list conditions,	Due to (or es e conseq	quenca of):				
60,	iclan a		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury						
ox 68760, certificate be executed	D 00	/Medical	thet initieted events resulting in deeth) Lest	Due to (or es e consequ	uence of):				
Box death cert	atten i for u	clan	B. 48 Oct 1 - 10 - 10 - 10 - 10 - 10 - 10 - 10						
P.O	igned by the attendir be deteched for use	by Physician	Pert II. Other significent conditions contributing to de	oth but not resulting in the ur	nderlying cause gi	ven in Pert I.		obacco uee cor ′es 2□ No	atribute to the cause of death? 3 ☐ Probably 4 Unknown
Vital Records, sicion: The law requires the	s been s 2 should	Completed I					24a. Wes o	en eutopsy med?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
<u>면</u> 를	ped						1 □ Y	es 2 No	1 ☐ Yes 2 ☐ No
of Vita Physician:		o Be	25. Wes case referred to medical exeminer? 1 Yes 2 No Hospital: 1 Ir	patient 2 ER/Outpetien	Oti	26. Plece of Deet			
	certific lirector,	atlon: To	27. Menner of Deeth 28e. Dete of		28c. Inju Wo		me 5 Resid 28d. Describe h		
= b	n. After this funeral di	<u>3</u>	3 ☐ Suicide 6 ☐ Could not be determined 28e. Placa	of Injury - At home, farm, stre g, etc. (Specify)	eet, fectory, office		28f. Location (S City or Tow		er or Rurel Route Number,
Ne Hospital	ner death. Nrector: After this in by the funeral di	Sertif		pest of my knowledge death	a consumed at the ti	me, dete end plece.	end due to the o	euse(s) end me	
To th	ner death. Nrector: After this in by the funeral di	edicai Certification:	29e. Certifier (Check only one) Certifying Physicien: To the la	sis of examination end/or Inv	vestigation, in my	opinion, deeth occurr	ed et the time, o	late end place,	nner es steted. and due to the ceuse(s)
	ner death. Nrector: After this in by the funeral di	Medicai Certif	(Check only 2 Medical Examiner: On the ba	sis of examination end/or Inv	vestigation, In my o	opinion, deeth occurr	red et the time, o	late end place, o	end due to the ceuse(s) d (Month, Day, Year)
	n. After this funeral di	edicai	one) 2 Medical Examiner: On the ba	sis of examination end/or Inv	vestigation, in my	opinion, deeth occurr se number	red et the time, o	late end place, e	end due to the ceuse(s) d (Month, Day, Year)

State Registrar JUL 15 1998

Registrer's Signature

Swidson-Randall



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** George Adolph Nocar 4b. City, Town, or Location of Death 1998 8:00 P.M. 10 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner BAITIMORE O Se d A.
If Undar 24 Hrs. STUARE Hospila nlex 1e 9. Birthplace (State or Foreign Maryland 7. Age (In yrs. last birthday) **Funeral** 213 12 6776 Months Days Hours 150 M 2□ F Director Usual Residence of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic svent, tra Mourcal Examinal must be notified at 1 ☐ Yas 2 ☐ No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 1444 Galena Road 21221 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within nd Mental Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) Brewer Brewing Company 18 Mother's Name (First, Middle, Meiden Sumama) 17. Father's Name (First, Middle, Last) seonge and Mental Pages 1 and 2 should be James Nocar Theresa Komenda 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a important: If item 27 is any injury or other tra Marguerite Nocar (wife) 1444 Galena Road Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other piace) Dete 20c. Location - City or Town, State Burial 2 Cramation 3 Removal from State Holly Hill Mem. Gardens 7/14/1998Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) 21 Side arvice Licenses Bruzdziński Funeral Home PA 1407 Old EAstern Avenue Essex, Maryland 21221 Inter the disease, or complications that daused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaase or condition resulting in death) · Asyslole 45 minutes Examiner Due to (or as a consequence of): Examine YEAR Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last physician a s the burial-Third 8 Physician/Medical POOR nulrition Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown B Lung Scarking Chronic signed d be det Records. À 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy CORONARY ARTERY Disease with Cononary 25. Was case referred to medical exeminer?

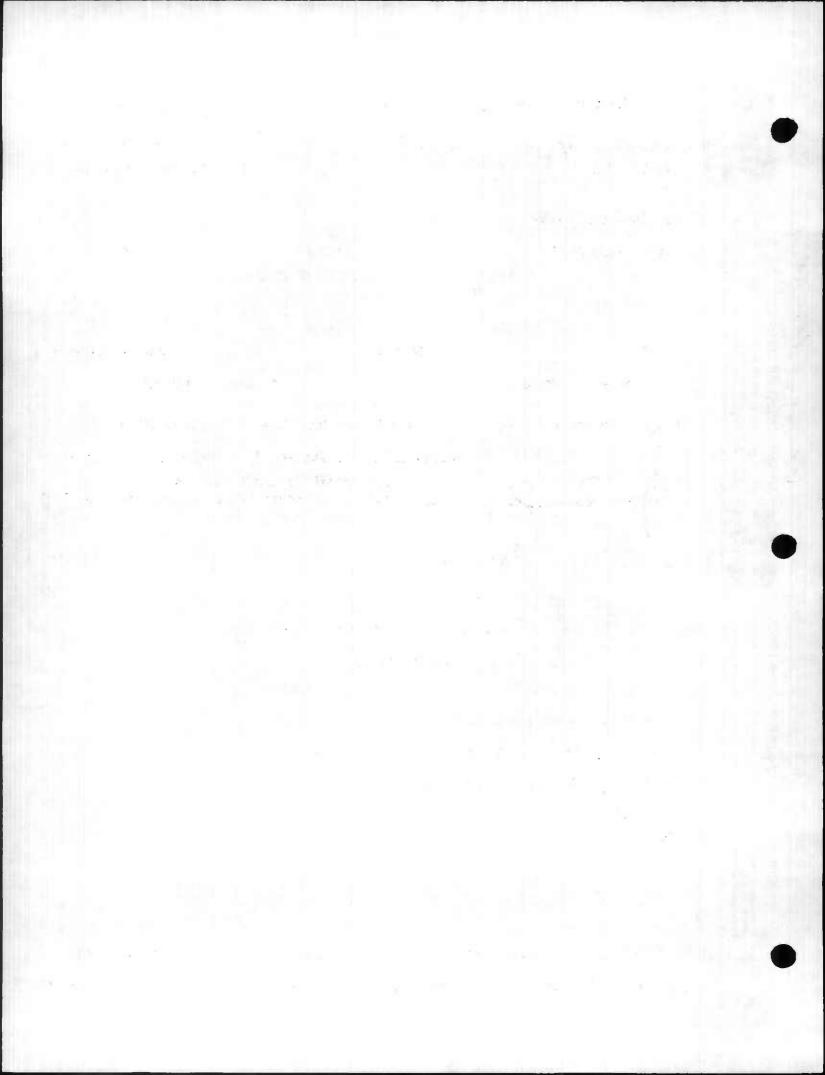
1 Yes 2 No

27. Manner completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 1916 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: Attending Neturel 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) after A 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Cartifier Medical 29b. Signature and title of certifier 29c. Licansa numbar 29d. Date signad (Month, Day, Year) Damuel & Wilson D38965 07-10-1998 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) DR. BALTIMORE, MARYLAND 21237 Squire Wilson 9000 FRANKlin

Registrar's Signature

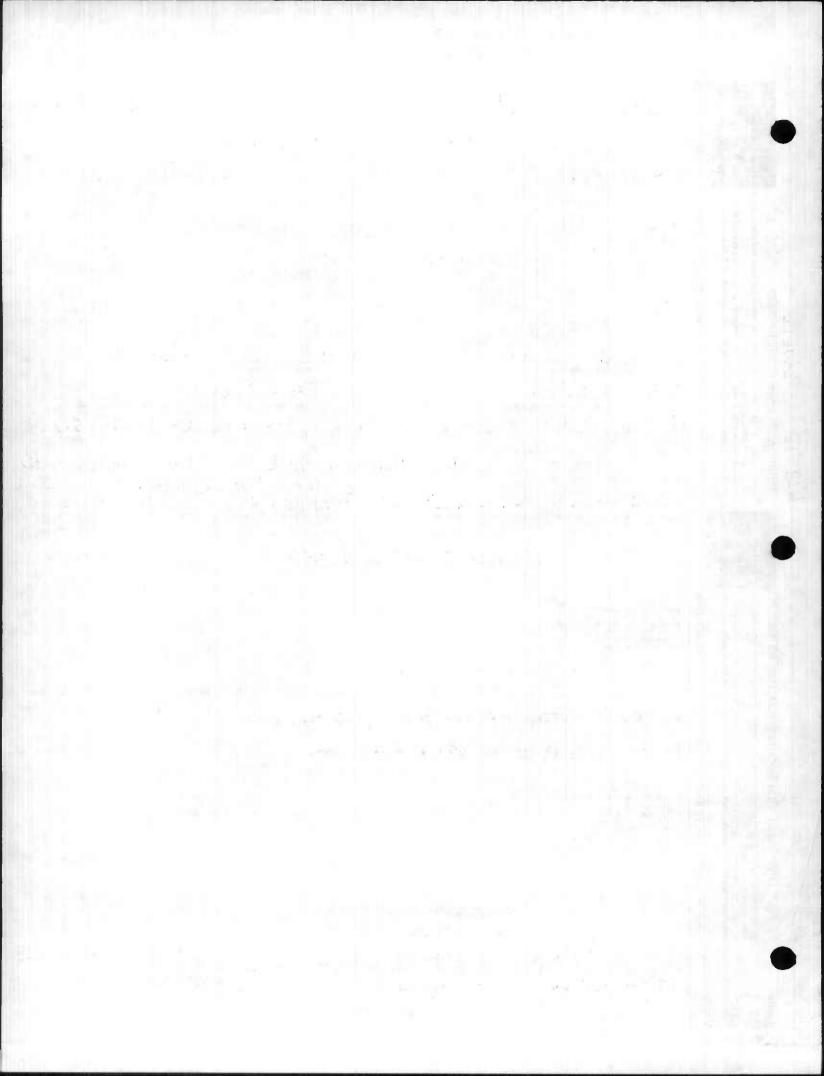
State Registrar DR SAMUEL

31. Dete filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 Decedent's Name (First Middle | ast) 2. Date of Deeth 3. Time of Death Month Day Year **Physician** 10.45PM YULY 1998 12 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner SALTIMORE If Under 24 Hrs. 8. Date NA INDALE If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□ M 25 F 214-20-5529 Usual Residence of Decedent Yrs. **Director** with the Meryland r 28a-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 125 Yes 2 No Altimore Director MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe if Health and Mental Hygiene. Itam 27 is merked other than "natural", or items 23s or other traumetic avent, the Medical Examines must be r 7260 21244 SARR Funerai death 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Yeer or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0020 1□ Yes 25 No Specify: by Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 3Rd NANNIE RIVATE NA GERGE 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be MARC HAILEY JOHN 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Important: if item 27 is nany injury or other transones. BARERD Michelle Dotson 7260 Stoney BAITO -daughter Baltimore, 20b. Place of Disposition (Neme of cemetery, crametory or other place) Data 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removel from State KANDALISTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) MEHOEIA Na 22. Name and Address of Fecility
Wm. C MARCH
4300 WABASH 21. Signeture of Funeral Service Licensee Home NERPI West Inc AUE, DA. BATO HD 21215 4300 Q. 94 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical · CANCER BREAST WITH METASTASES 4 MONTHS **Examiner** Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or Injury that Initiated events resulting In death) Last Due to (or as e consaquance of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of) 88 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yee 2 No 3 Probably 4 Unknown CORDNARY ARTERY DISEASE, OLD MYOCARDIAL Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HYPERTENSION, ATRIAL FISRILLATION page 2 s 2 No 1 Yes 2 No 1 Yes certificate or Attanding Physician: director, 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only one) Hospital: To Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1□ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 ☐ Pending s efter death. 2 No 1 Yes Investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicida Hospital 24 hours Funeral 1 Certifying Phyelclan: To the best of my knowledga, daath occurred at the time, data and place, and dua to tha cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to tha cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and that of certifier ATTENDING D 25610 JULY. 13. 1998 PHYSICIAN SET HTWAR 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) LEVINDALE 2434 BELVERDERE BALTIMORE WEST AVENUE 21215 32. Raginarias Siscorias 31. Date filed (Month, Day, Year) JUL 15 1998 State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 13 Pay 21,32AM TIAdus 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Nama (# not institution, giva street and number) If Undar 24 Hrs. | a P christ JURSIN9 HOME If Under 1 Year 8. Data of Birth (Month, Day, 5 28 Birthplaca (Stata or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) 1 M 2 F Months Days Hours 217-24-6484 Usual Rasidance of Dacedant Yrs 10a. Stata 10b. County 10c. City, Town or Location 10d. instda City Limits 17 Yas 2 No Altimore 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 3922 AUE 21216 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Reca - Amarican tndien, Black, Whita, atc. 11. Maritel Stetus 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 ☐ Yes 2 ZNo Specify: 3 Widowed 4 Divorced Black 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Director Etamantary/Secondary (0-12) Coltaga (1-4or 5+) 4 Yes 12+H GRAdE ENTER (12EN (114 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) BREWINGTON ILLIAMS 19a. Informant's Name/Ralationship (Type, Print) HUSbaud 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) AUE BALTO 3922 VAII LAUDE Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stete 20a. Mathod of Disposition Data 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 98 Foesst 4 ☐ Donation 5 ☐ Othar (Specify) JUINGS TAPPISON 22. Nama and Addrass of Facility WM C MARCH 21. Signatura of Funaral Sarvice Licensas FUNERAL Home Wm C Entir the disasse, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cabe on each line. Approximata Intarval Between Onset end Deeth Immediata Causa (Final disaasa or condition rasulting in daath) CANCER rine 4 Years Dua to (or as a consaquance of) Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Dua to (or as a consaguance of) that initiated evants rasulting in death) Last Due to (or es a consequença ot). 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No 24b. Wara sutopsy findings availabla prior to complation of cause of death? 24a. Was an autopsy performad? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospice 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how tnjury occurred 28b. Tima of 1 Natural 2 Accidant 5 Panding

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other trsumetic event, the Modical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, the Medical Examiner must once.

Baltimore, Maryland 21215-0020

with the Maryland

Examiner physician Physician/Medical 8 8 990 94 signed by þ Completed

certificate has

Anny mis or Attend after death Director: To the Hospital of within 24 hours a To the Funeral D

PATTERSON, GLADS

State Registrar

Certification: To

edical

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Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifia (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and little of

1 ☐ Yas 2 ☐ No

len

28a. Ptace of Injury - At homa, farm, streat, tactory, office building, atc. (Specify)

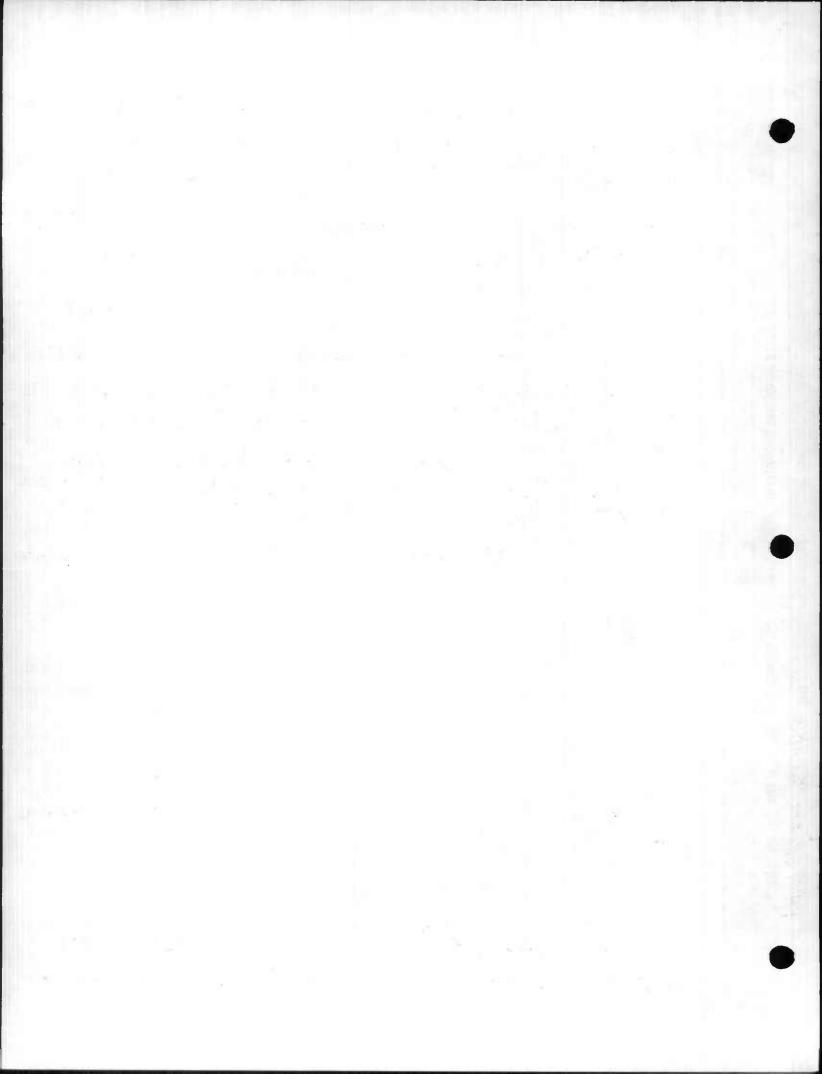
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print)

Charles St Bolto, Md 21204 104 31. Data filed (Month, Day, Year) 32. Regtstra

invastigation

Could not be datarminad



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2:30am Christina Popa-Holt · /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner GIEN BURNIE If Under 24 Hrs. 8. Dete of Birth ARUNDEL 7. Age (In yrs. last birthday) . COUNTY 8. Dete of Birth (Month, Dev. Year March 29, If Under 1 Year 5. Social Security Number Funeral Days 1□M 2√ F 95 Yrs. 1903 Maryland 220-44-8297 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours aftar death with the Manylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any lightry or other treumatic event, Iffa Medical Edutine must be notified at any lightry or other treumatic event, Iffa Medical Edutine must be notified at Y Yes 2 No Director Md. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1505 Park Avenue 21217 U.S.A. Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Reca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes a No Specify: Aq 3 □XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Minister Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Simon Smolsky Amelia Mach 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 8045 Fort Smallwood Road Balto., Md. 21226 e of Disposition (Name of Date 20c. Location - City or Town, State Leonard J. Popa (Grandson 20b. Place of Disposition (Neme of cametery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Meadowridge Memorial Park 7/15/98Elkridge,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Facility 21. Signature of Funeral Service Licenses McCully-Polyniak Funeral Home 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arest, Md. 21225 shock, or heart feiture. List only one cause on each line. Interval Between Onset and Death Physician PNEUMONIA /Medical Immediate Cause (Final disease or condition resulting In death) 1 WEEK Examiner Due to (or as a consequence ot): Examiner ed by the attending physician and detached for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown 20 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peed completion of cause of death? this certificate has 1 Yes 2 No 1 Yes 2€ No 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? After 5 Pending Investigation 1 CHatural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one)

Box 68760 Division of Vital Records, P.O. Attending Physician: after death

death.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

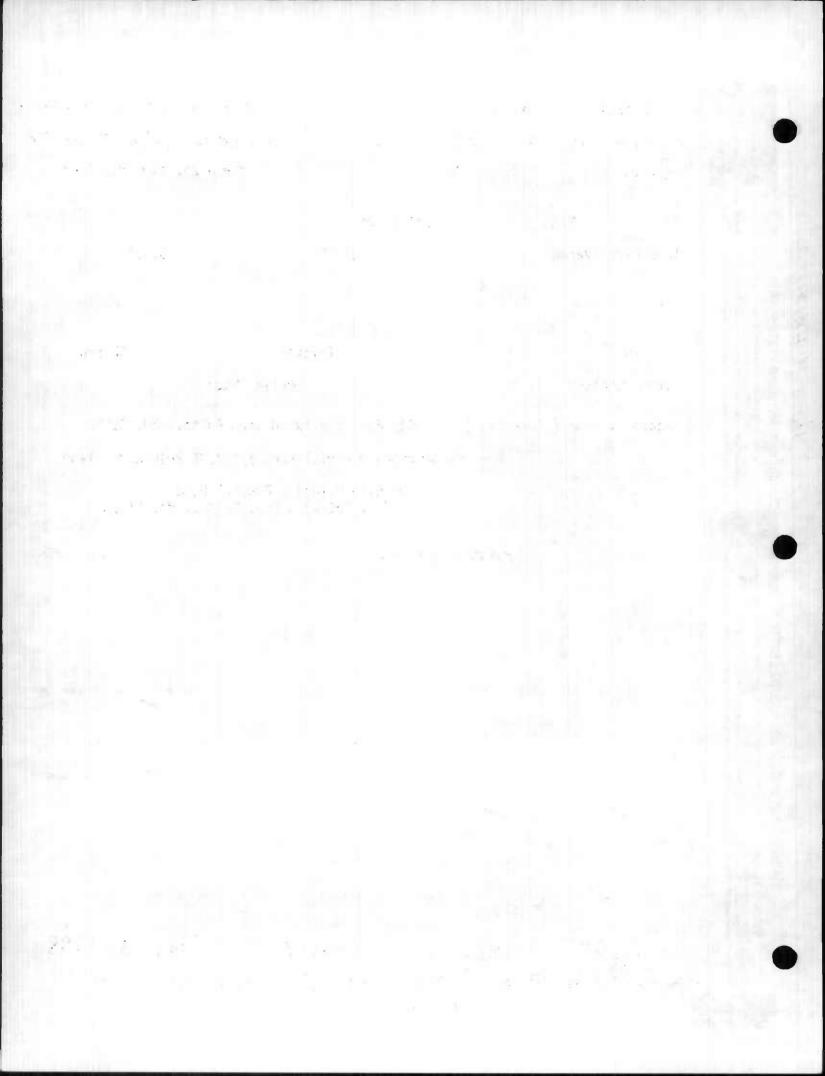
30. Name and add

us of person who completed cause of death (Item 23a) (Type, Prin 32. Registrar's Signature

29c. License number

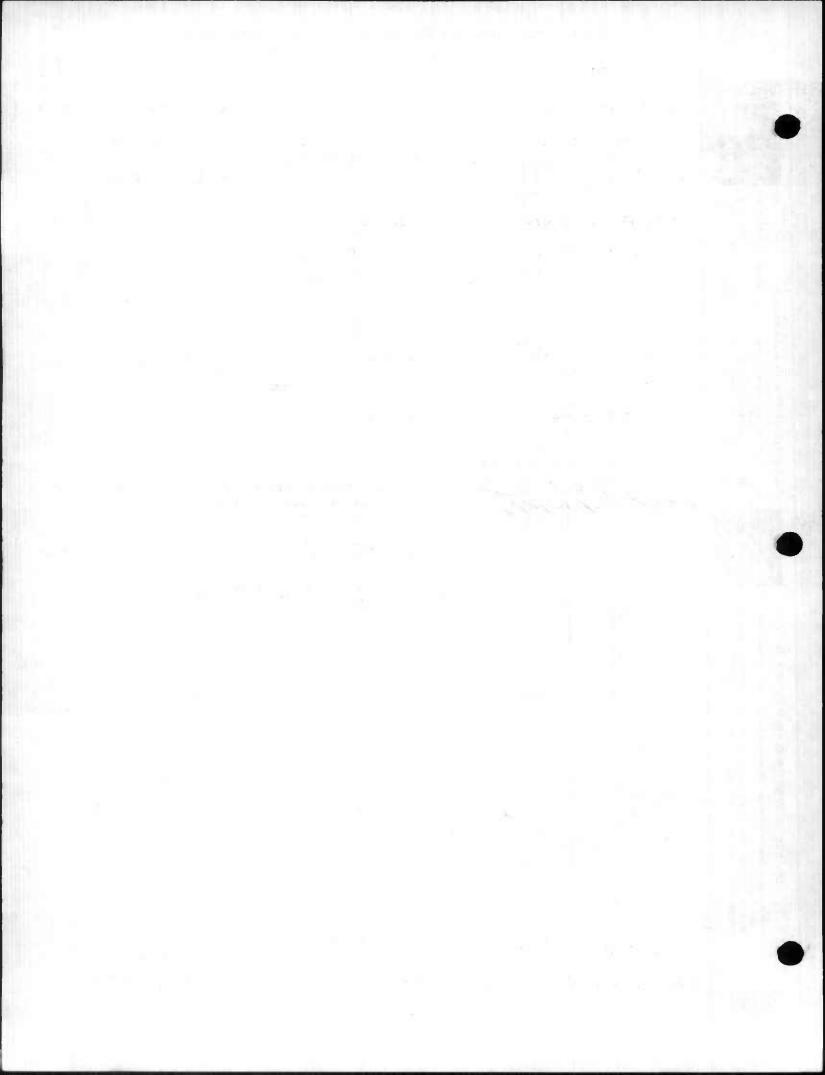
DSLIVE, GLOW BURNIE, MO. 21061

29d. Date signed (Month, Day, Year)

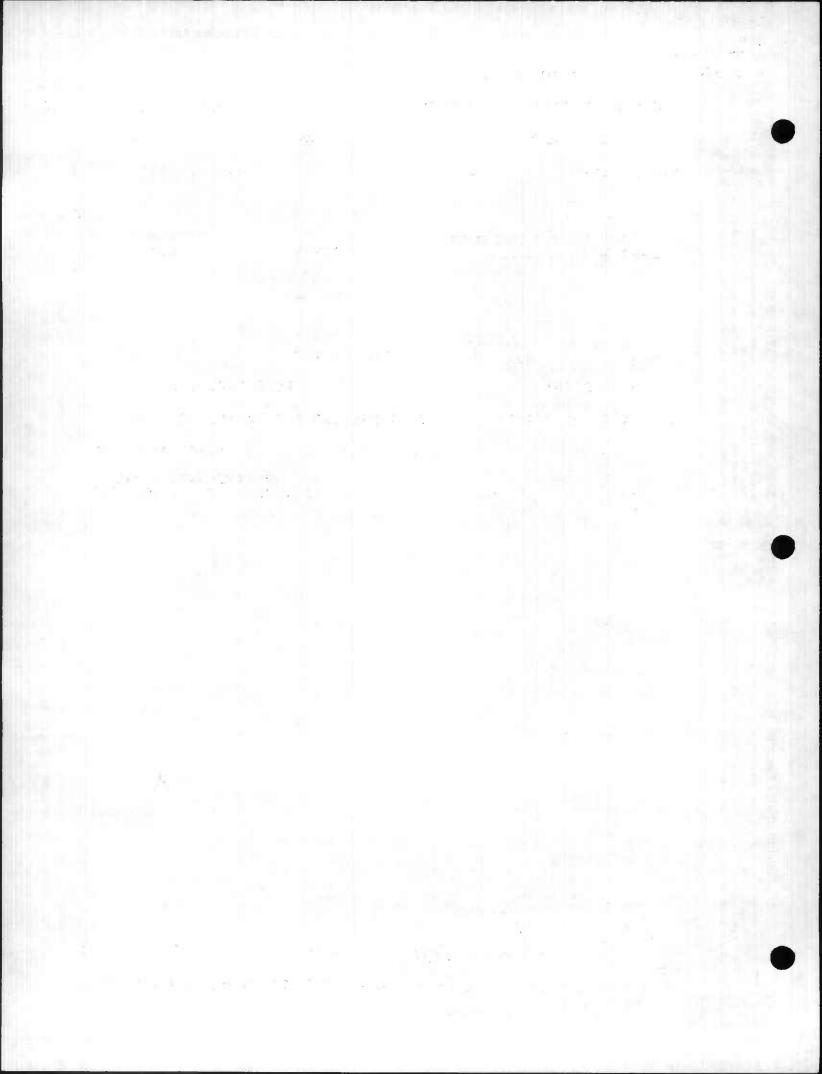


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

10. Zp Code 20910 109, Clitzen of What Country? 1. S. A. 1. Maria Status			. Decedent's Name (First, Midd	3761 7-15- lie, Last)			Certificate		2. Date of		11.	. 1	3. Time of De
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29e. Certifler (Check only one) 29e. Certifler (Check only one) 20e. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	To Be Completed by Physician/Medical	P	as ulting in death) Last art II. Other eignificant conditi 5. Was cesa referred to medice examinar? 1 □ Yas ☒☒ No 7. Manner of Death 1 ☒️Netural 5 □ Pendi	Hospital:	Due to death but no	to (or as a con	atlent 3 DOA e of y	26. Place of Other: 4 \(\text{Nursin} \) Nursin Injury at Work?	23b. ii 24e. V p 1 Deeth (Check or	Old tobacc Yee Yes an eutrerformed? Yes :	Popsy No No 6 □Othe	24b. Were evaluation of d	re autopsy findi liable prior to spletion of ceus eath? Yes 2 No
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JB A 25		ONY ITEMS:# 23 PART Item 10e Per FH Decedent's Name (First, Middle, JAMES ANTE	Last)	OBINS				2. Date of D Month JULY	eath Day	Year	3. Time of Death 02:10 A
/Medica Examine	4.	a Facility Name (If not institution,			014		4b. City, Town,	or Location of Dea			02:10 A
		1513 EAST CHAS					BALTIM		1	N/A	
Funeral Director		Social Security Number 218-80-5733 Isual Rasidence of Decedent	6. Sex 1 ☑ M 2 □ F	7. Age (In yrs. 41		Under 1 Year onths Days		Hrs. 8. Date of B (Month, D MAY 5	irth Pay, Year) , 1957	9. Birthpl Count	ace (State or Foreig ry) MD
with the Maryland a or 28a-f show the northed at	-	0a. State 10b. County N/			ty, Town or Location	BALTO					od. Inside City Limit 1 Nes 2 □ N
23a or 20	1	0e. Street and Number 1513 -2400 ASHLAN		STREET	1	Of. Zip Code 21	205		U.S.		iry?
or items		Marital Status Never Married 2 Marrie Midowed 4 □ Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv Year or De	ces? 2 No	If Yes	Decedent of I- s, specify Cub Yes 2 XNo	an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	Blac	ce - America ck, White, e y: BL	etc.
natural.		15. Decedant's	s Education		16a. Decedent's	s Usual Occup	pation	working	16b. Kind of Bi	usinass/Ind	ustry
		Elementary/Secondary (0-12)	College (1	-4or 5+)		EMPLO	during most of	WOIKING		N/A	
I S C		7th 7. Father's Name (First, Middla, L	ast)		ON	EMPLO	1	Name (First, Middle	1	-	
end Mentel is merked or sumetic eve	2	JAMES BRIGH						E ROBIN			
		9a. Informant's Name/Relationsh DARLEN STORE						BALTO,			Code)
ant: If item 27 ury or other tr	2	0a. Method of Disposition 1 GBurial 2 Cremation 4 Donation 5 Dother (Sp.		20b. F	Place of Disposition cometery cremato. ZION	n (Neme of ry or other pla CEM	осе)	7-14-9	20c. Location - 8 BALT(
Department of Department of Important: If it eny injury or once.	2	1. Signature of Furieral Service L	icenses Atto	4	22. Na 112	9 N.C.	AROLIN	BETTS FU IE ST BA	NERAL I	HOME 212	13
	1	23a. Part 1. Enter the disease, or o shock, or heart failure. List o	complications that con only one cause on e	used tha deat ach line.	h. Do not anter th	e moda of dyi	ng, such as ce	diac or respiratory	arrest,		Approximate interval Between Onset and Death
hysician /Medical Examiner	r	mmediate Causa (Final lisease or condition esulting in death)	a. NAF	ULA	ITOXICATION or as a consequance					1	
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nes been si e 2 should		E Was soon referred to medical					00 Di -4		Yas 2 No	10	Yes 2□ No
ate hes b page 2 si	1 4	5. Was cese rafarred to medicel eyeminer? 1 Yes 2 No	Hospital:	patient 2	ER/Outpatient 3	DOA Oth	hor	Death (Check only		ner (Specify	•)
tificate hes b		7. Manner of Death	28a. Data d	f Injury h, Day Year)	28b. Time of Injury	28c. Inju		-	how injury occur		
his certificate hes b				7-8-98	UNKNOWN		Yes 2 No	UNKNOWN 28f. Location	(Street and Numt	ber or Rura	Route Number.
his certificate hes b		1 ☐ Naturai 5 ☐ Pending 2 ☐ Accidant investigs 3 ☐ Suicide 6 ☐ Could no	ot be	of injury - At h	oine, laini, shoot,	lactory, office		City or To	own, Stete) 151 [MORE, MD	13 E. C	HASE ST
ector: After this certificate has b by the funeral director, page 2 si		1 Naturai 5 Pending investigation	28a. Place buildir	of injury - At higg, etc. (Specif)ME	(y)			DALII	HORE, HU		MINUL UT.,
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene rja Certificate of Death Reg. No. 2. Date of Deeth Month bin son 1998

25

Item 26 Per PHY Film G761 7-15-98 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** egina /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 21 7. Age (In yrs. last birthdey) 5. Sociel Sacurity Number If Under 1 Yaar If Under 24 Hrs. 8. Deta of Birth Mooth, Bay, Year) NOV 23, 1928 6. Sex Birthpleca (Stata or Foreign Country)
 MD **Funeral** Months 1□ M 25 F 69 Deys Hours Min. 214-26-4334 **Director** Usuel Residance of Decedant the Maryland 10e. Stata 10b. County show 10c. City, Town or Location r 28a-f show 10d. Inside City Limits MD N/A Director BALTO 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with ral', or Itams 23a or 1121 N. LUZERNE AVE Funeral 21213 Peges 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. https://ems.27.is.marked.other.then "natural", or Itams 23. U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Dacedant of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yes ②☐No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: BLACK þ 3 Widowed 4 Divorced Yaer or Detes: Completed other traumatic event, the Medical 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th TEACHERS AID 3yrs SCHOOL SYSTEM 17. Fethar's Neme (First, Middle, Lest) 18. Mother's Name (First, Middla, Maiden Sumeme) Be LEEWOOD JACOBS ALEASE TUCKER 2 19e. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) 3301 EMLEY A

20b. Plece of Disposition (Name of cametery, cremetory or other pleca) EARLINE ROBERTS EMLEY AVE BALTO, pate MD 21213 20e. Method of Disposition 20c. Location - City or Town, Stete Department of H Important: If its any injury or of once. 1 XBuriel 2 ☐ Cremation 3 ☐ Ramoval from State MT. ZION CEM 7-15-98 BALTO, MD 4 Donation 5 Other (Specify) 21. Signeture of Funeral Service Licenses 22. Neme and Addrass of Fecility BETTS FUNERAL HOME 1129 N. CAROLINE ST 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceusa on each line. 21213 Approximata Interval Batween Onset and Death **Physician** Immediata Ceuse (Final disaasa or condition resulting in deeth) /Medical **Examiner** Physician/Medical Examiner Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disease or Injury that initiated evants rasulting in deeth) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 6876 Due to (or es e consequence of) for use as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an eutopsy peeu performadi

has certificate

Completed 25. Wes case refarred to medical exeminer? Be Certification: To 27. Menner of Deeth 29a. Cartifier Medical

this after death.

or Attending Physician: The law requires that the death certil To the Hospital or Atter within 24 hours after des To the Funeral Director completely filled in by th

> State Registrar

N. BROADWAY 31. Dete filed (Month, Day, Year)

29b. Signature and title of certifiar

1 Yes 2 No

1 Naturel 2 Accident

3 Suicide

4 - Homicide

(Check only one)

SUITE YOU 32. Begistrer's Signeture

Hospitel:

5 Pending investigation

6 Could not be datermined

28a. Date of injury (Month, Dey Year)

and eddress of person wito completed causa of daeth (Itam 23e) (Type, Print)

1 Inpatient 2 ER/Outpatient 3 DOA

28a. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28b. Time of

28c. Injury et Work?

Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data end pleca, and due to the ceuse(s) and menner es steted.

| Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, daeth occurred at the tima, data and plece, and dua to the causa(s) end manner steted.

29c. License number

1 Yes 2 No

BALTO, MD. 21231

26. Plece of Daeth (Check only one)

Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify)

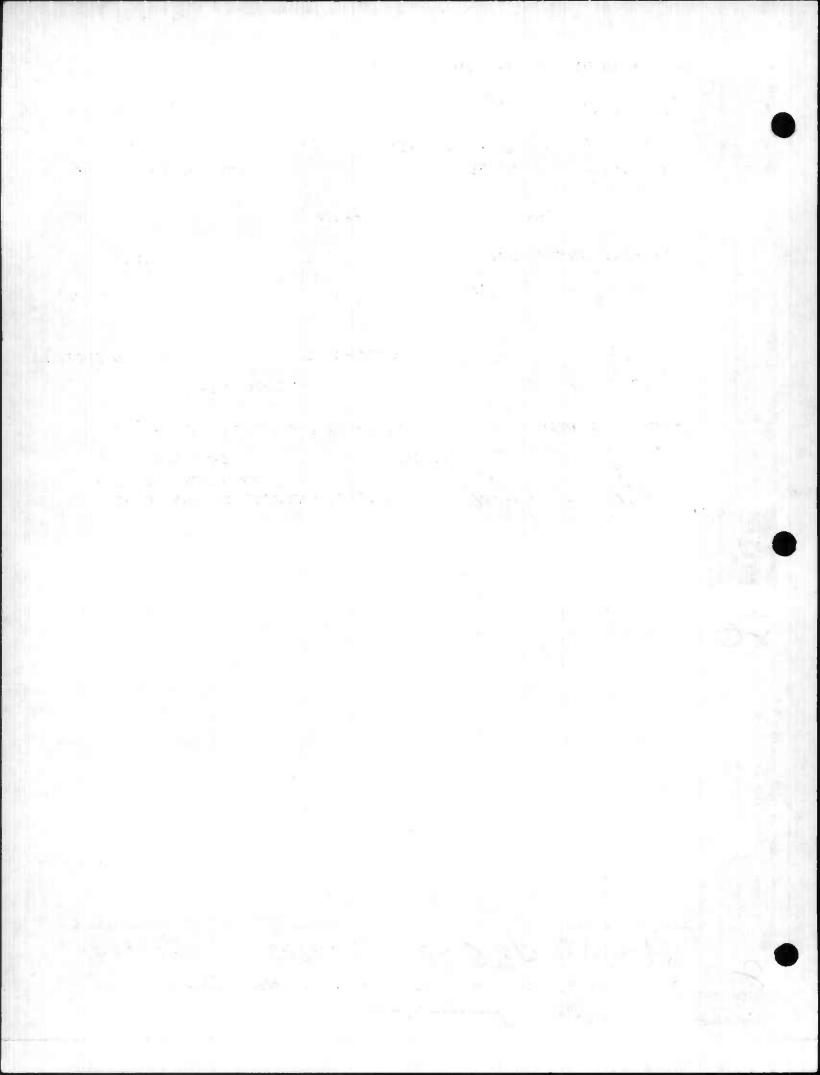
1 Yas 2 No

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

29d. Date signed (Month, Dey, Year)

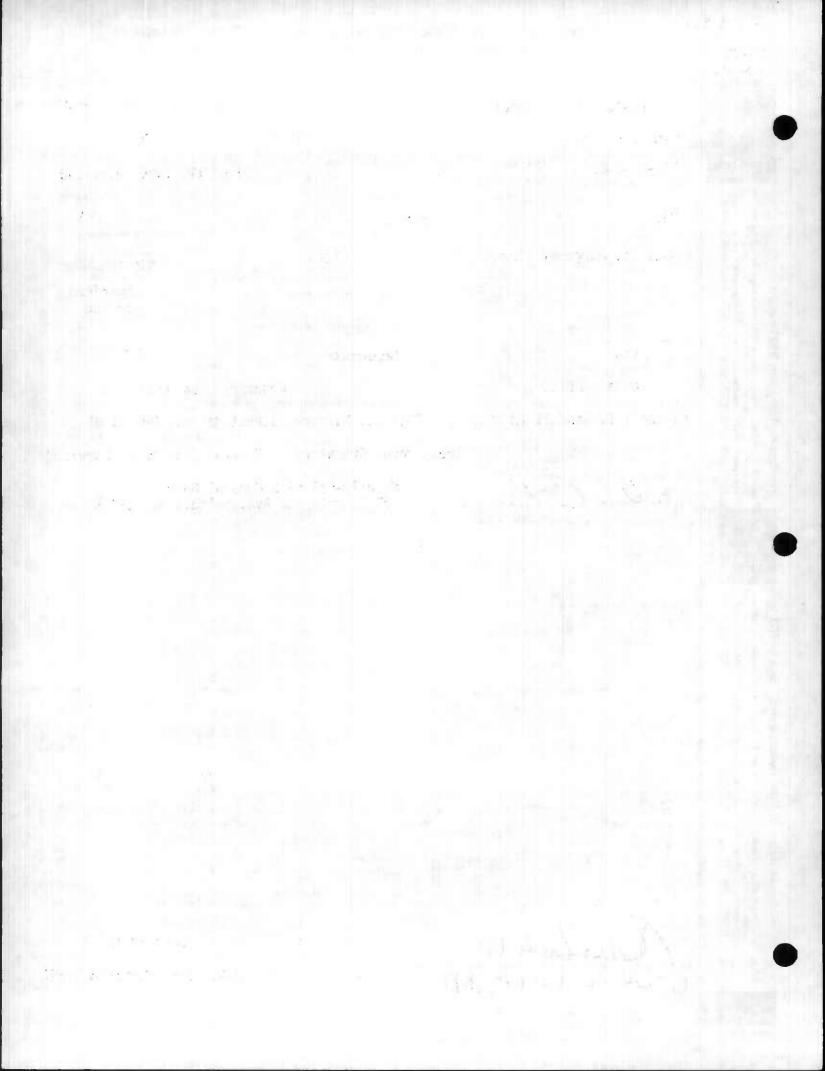
1 Yes 2 No



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Physicia Physicia	_	1. Decedent's Neme (First			EO G761				Death		2. Date of De Month	Day	Year	3. Time of Death
· /Medic		Angela	D.	Randall					1. Oh. T		JULY		998	9:26P.M.
Examin	er	4a Facility Neme (If not it HARBOR HOS!		e street and numb	oer)			1	BALTI		cation of Deat			
Francis		5. Social Security Number		Sex 7.	Age (In yrs.	last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Bir (Month, De		A 9. Births	placa (State or Foreign
Funeral Director		218-88-249	2	1□M 2☑F	32	Yrs.	Months	Days	Hours	Min.	June 1	7, 1966		yland
ytand M M		10e. State 10b.	. County		10c. Ci	ty, Town or Lo	ocation						1	0d. Inside City Limits
o Mar	otor	Md.	N/A			Baltim	ore							1√ Yes 2 No
with the Marylar a or 28a-f show be notified at	Director	10e. Street and Number					10f. Zlp	Code				10g. Citizen of	What Cour	ntry?
offi w		3617 St. Ma	argare					2122				U.S	.A.	
them the co	Funeral	11. Marital Status	OF Wassels	12. Was Decede	es?	,S. 13.	Was Deced	dent of H cify Cuba	ispanic Orig in, Mexican,	Puerto I	cify Yes or No Rican, etc.)	Ble	ce - Americ ick, White,	etc.
f, or	by	1 Never Married 2		1 Tes 2 If Yes, Give Year or Date	AP 140 es:		1□ Yes 2	No No	Specify:			Specia	y.Amer	
d within 72 hours at plene. I than "natural", or the Medical Exam	pe	, 15. I	Decedent's E	ducation		16a. Dece	dent's Usue	el Occup	ation			16b. Kind of B	Indi Business/in	
Med .	Completed	Elementary/Secondary		ede completed) College (1-4	or 5+)	life.	DO NOT us	se retired	during most f)	OI WOIKII	ng			
and the state of t	Con	9th		0		Н	omema	ker					Home	
d days a constant	m	17. Father's Name (First,										, Maiden Sumai	me)	
d Mer d Mer marke	70	James 19e. Informant's Name/F	Able			10h Maii	no Addrono	/Ctroot		osem		La Grew er, City or Town	Ctate 7in	Code
7 is 7		Mitchell T.			and)							to., Md		
Ham 2 Ham 2 Other	-	20a. Method of Disposition		. (11435)	20b. I	Place of Dispo	osition (Nan	ne of		3616	Date	20c. Location		
Sages ant of the fifth		1 Burial 2 Cre 4 Donation 5 D	omation 3 E	Removal from St	ate Gre	en Mou	nt Cr	ema t	ory	77	16/98	Baltimo	re. M	arvland
ermit. Pages 1 i Nepartment of He mportant: If Item my injury or oth	1	21. Signature			6	2	2. Name an	d Addres	ss of Facility	/				
Deg		Al.	1	SU.	1113	M	cCull.	y-Po	lynia	k Fu	neral	Home		
1000		23a. Part1. Enter the dis	2000 07 000	lum		, ,								
Physician			sease, or com	plications that cau	sed the dear	th. Do not en	ter the mod	Pat le of dyin	apsco	Ave	Balter respiratory a	o., Md.	2122	Approximate
		shock, or heart failu	ure. List only	plications that cau one cause on eac	ised the dear th line.	th. Do not en	ter the mod	Pat le of dyin	apsco	Ave	Balter respiratory a	o. Md.	2122	Approximate Intervel Between Onset and Death
/Medical		Immediate Cause (Final disease or condition	ure. List only	one cause on eac	an line.	th. Do not en				Ave	. Baltır respiratory a	O., Md.	2122	Intervel Between
Examiner		shock, or heart failt	ure. List only	one cause on eac	AMIL AN		HOL INT			Ave	. Balt r respiratory a	O., Md.	2122	Intervel Between
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JUL 151998 Stan Lavidson Randese



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2 Date of Death 3. Time of Deeth TO DINSON JULY 7:15 AM CY 4e. Fecility Neme (Innot institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Joseph'Richev Hospice Baltimore if Under 24 Hrs. 5. Sociel Security Number If Under 1 Yeer 6 Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Months Days Hours Min. 1□ M 2□ F 343-24-3412 Yrs. 68 DEC. 13, 1929 Illinois Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. 1 Yes 2 No N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 828 Utah Street 21201 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 6 Baltimore School Sys. Teacher 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Andrew Orford Alice Andrews 19e. Intorment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Sister 475 Gillett Street, Fond du Lac, Wisconsin Sister Martin de Porres Orford 54935 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 7/_{12/98} 1 ☐ Buriel 2 M Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Washington Crem. Laurel. Md. 21. Signature of Europeal Service Licenses 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkrid
compare the Aused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. 7250 Washington Blvd., Elkridge, Md. 23a. Pert1. Enter the disease, or const shock, or heart feilure. List only Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) . COLON CARCINOMA WITH METASTASES THONAK Due to (or es e consequença of). Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequence ot): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were eutopsy tindings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 20 No 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HOSPICE 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending Investigation 1 Tyes 2 No 2 Accident

Physician /Medical Examiner buriel-tran death certificate be exec

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Division of Vital Records, P.O. Box 68760

Physician

/Medicai

Examiner

Director

by

Completed

Funeral

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7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Modical Experiest must be not find at

should be filed within 72 hours after ond Mental Hygiene.

marked other than "natural", or item

Pages 1 and 2 should be filt ment of Health and Mental Hyant: If Item 27 is marked oth jury or other traumatic event

Baltimore, Maryland 21215-0020

the Maryland

Examiner Physician/Medical by Completed

> 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 - Homicide

1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted. 2 Medical Examinar: On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner steted.

Location (Street end Number or Rurel Route Number, City or Town, State)

29b. Signatu

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101 N READ ST SOITE 719 BALTIMONE MD 21201 MACGIBBON 31. Dete tiled (Month, Day, Yeer)

State Registrar

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Certification:

29a. Certifier

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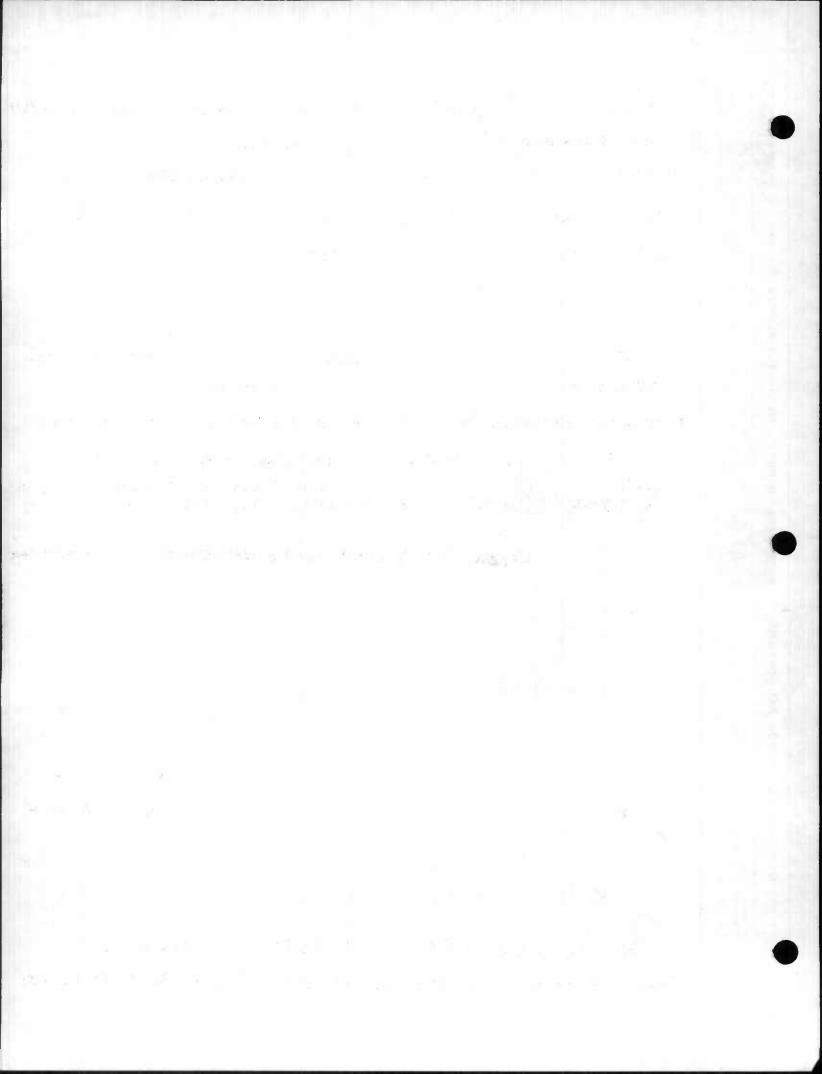
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32. Registrer's Signeture Julia Davidson-Randalle



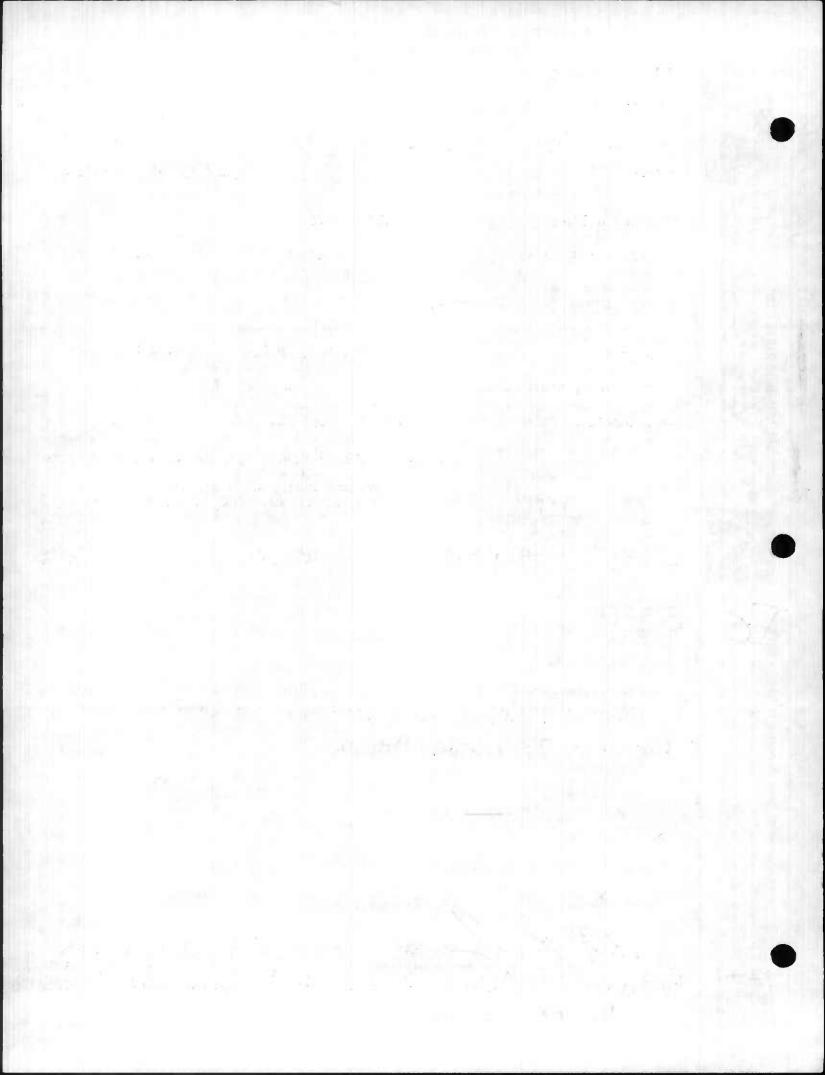
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend: #26 Per MD Film G762 8-17-98RC 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** George Henry Staab, Jr. 12, 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loc Examiner ltimore HOSPITAL
7. Age (In yrs. last birthday) IONKIN 8. Date of Birth (Month, Day, Year) April 23, 1925 5. Social Security Number 9. Birthplece (State or Foreign Country) Maryland **Funeral** Days 10 M 2□ F Months 218-16-1826 73 Yrs. Director Usuel Residence of Decedent with the Meryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Perry Hall TROAG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21128 U.S.A. 4702 E. Joppa Road Herrs 23a Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ¼ Yes 2 □ No If Yas, Give Year or Detes: WW II 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 ☐ Never Married 2 Merried "naturel", or 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within nd Mental Hygiene. marked other than Elemantery/Secondery (0-12) College (1-4or 5+) U.S. Government Sheet Metal Model Maker 12th grade 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nema (First, Middle, Last) Pages 1 and 2 should be and Mental Margaret T. Schutte George Henry Staab. Sr. 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Department of Health a Important: If hem 27 le eny Injury or other tre 4702 E. Joppa Rd., Perry Hall, MD Mrs. Louise E. Staab (wife) Baltimore, 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removal from State St. Joseph Church Cem. 7/16/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility
Schimunek Funeral Home, Inc. 21. Signeture of Funerel Sarvice Licensee marke T. 9705 Belair Rd., Baltimore, MD 21236 23e. Part1. Entar the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, if eny, laeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting In deeth) Lest Due to (or es a consequence of) Physician/Medical Due to (or as e consequence of): The law requires that the death certifical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? 3 Probably 4 Unknown 2 ripheral Vascular 1 Yes 2 No signed b Records, 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy Mansient Ischemic peen i certificate her 2 No 1 ☐ Yas 1 □ Ves 2 □ No Division of Vital or Attending Physician: director, 8 25. Wes case referred to medical examiner? 26. Placa of Deeth (Check only one) Hospital: 12 Insertion 2 ▼XER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident within 24 hours efter deeth To the Funerel Director: / completely filled in by the f 6 Could not be datermined 3 Sulcide 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide Hospital 1) Cartifying Physician: To the best of my howledge, deeth occurred et the time, data end piece, end due to the ceuse(s) and mannar as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signeture and title of continue 29c. Licanse number 2 30 Name end eddrass of person who completed od use of death (Itam 23a) (Type, Print) Franklin Square Baltimore, MD 9000 31. Date filed (Month, Day Year) 32. Registrar's Signature State

DHMH 16 Rsv 6/95

Registrar

JUL 151998

relia Davidson



					Cer	tificate d	of Death		Reg. No.		
Physicia	n .	Decedent's Neme (First, Middle, Last	LEE			SULS	FR	2. Date of De	Pay Pay	1998	3. Time of Death 21:05
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mil. Pages 1 ar partment of Hea portant: if Item; y Injury or other	2	10a. Mathod of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Othar (Specific	Removal from State	cer	metary, crem	sition (Name of latory or other t Crema	place)	Date /1998	20c. Location		own, State (Aryland
permit. Departimportu eny inj ozice.		21. Signature of Funeral Service Licen 23a. Phr. Enter the disease, or com- shoot, or haart failura. List only	D	the death.	1.	407 016	Idress of Fecility ISKI FUNETA I Eastern A dying, such as cardial	Avenue E	ssex, N	Maryla	and 21221 Approximete
Physician /Medical		shool, or haart failura. List only mmediata Causa (Final disease or condition									interval Between Onsat and Death 3 hours
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rect rect	9 2 0 Be	25. Was casa rafarred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	a. aOE	D/Outnotion	2□ 004	Other:	ath (Check only o		ther (Engel	6.1
수 물을 나	-	27. Manner of Death 1 Matural 5 Panding 2 Accident Investigation	28a. Data of Injur (Month, Day		R/Outpatien 28b. Time of Injury	28c.	njury at Work? 1 Yas 2 No	lome 5 ☐ Resi 28d. Describe			у/
or Attending s after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injubuilding, etc	eet, factory, off	28f. Location (City or To		nber or Run	al Route Number,			
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To the within 2 To the comple		29b. Signature and title of certifier				29c. Lic	ense number		29d. Date sign	ed (Month,	Day, Year)
		I Suny Devi	, M.D.			R	ES-000		July	998	
15		O. Nama and addrass of person who sanjuy Desai, M.D.	Tower	110	POHN	5 HOPKI	NS HOSPITA	- Balti	more t	layle	and 2120
State Registra		1. Date filed (Month) Day, Year) 5	998 32. Register	irs Signatu	toon R	ndece					

Registrar

TERRITOR STORY STORY STORY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month **Physician** Antonio Reyes Santos 13 1998 1:37 P.M. July /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) **Examiner** Keswick Multi-Care Center Baltimore N/A If Under 1 Year It funder 24 Hrs. Months Days Hours Min. Month, Days Hours Min. Jan. 5, 1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** 1 X M 2 □ F 215 94 3503 65 Yrs. Philippines Director Usuel Residence of Decedent with the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or itema 23a or 28a-f ahow the Modical Examiner must be notified at 1 TYes 2 □ No Baltimore Directo Maryland 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 816 E. 33rd Street 21218 parmit. Peges 1 and 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene. important: If item 27 is marked other than "naturel", or itema 23a enth Injury or other traumatic event, the Medical Examines must place. Philippines Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Yeer or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 1⊠Yes 2□No Specify: Filipino Specify: Filipino P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Taylor 12th Clothing 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Magdaleno Socorro Reyes Santos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonio Santos Jr. / son 816 E. 33rd Street Baltimore, Maryland 21218 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Taytay, Rizal, Philippines 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Taytay Cemetery (unknown) 21. Signeture of Funeral Service Licenses 22. Neme end Address of Facility Gonce Funeral Home P.A. Baltimore, Md. 4001 Ritchie Highway 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Aspiration 1 Hour Examiner Due to (or as e consequença of): Physician/Medical Examiner Supranuclear Palsy 2 Years physician and the buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Due to (or as e consequence of) 88 USB 0 signed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Coronary artery disease S/P þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed Bypass grafting completion of cause of deeth? certificate has b lirector, page 2 s 1 Yes 2 No 1 Tes 2 No Physician: 25. Was case referred to medical Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Mother Specify Center Hospital: To 1 Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation

Division of Vital Records, P.O. Box 68760 After death.

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or Attending after

24 hours after Funeral Dire letaly filled in b Hospital To the Hosp within 24 hor To the Fune completaly fi

Registrar

edical

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of cartifier

6 Could not be determined

M. Dadelle mae

M. Isabelle MacGregor M.D. 700 W. 40th Street 31. Dete filed (Month, Dey, Year) JUL 151998

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

July Davidson-Rondall

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) end manner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and manner stated.

29c. License number

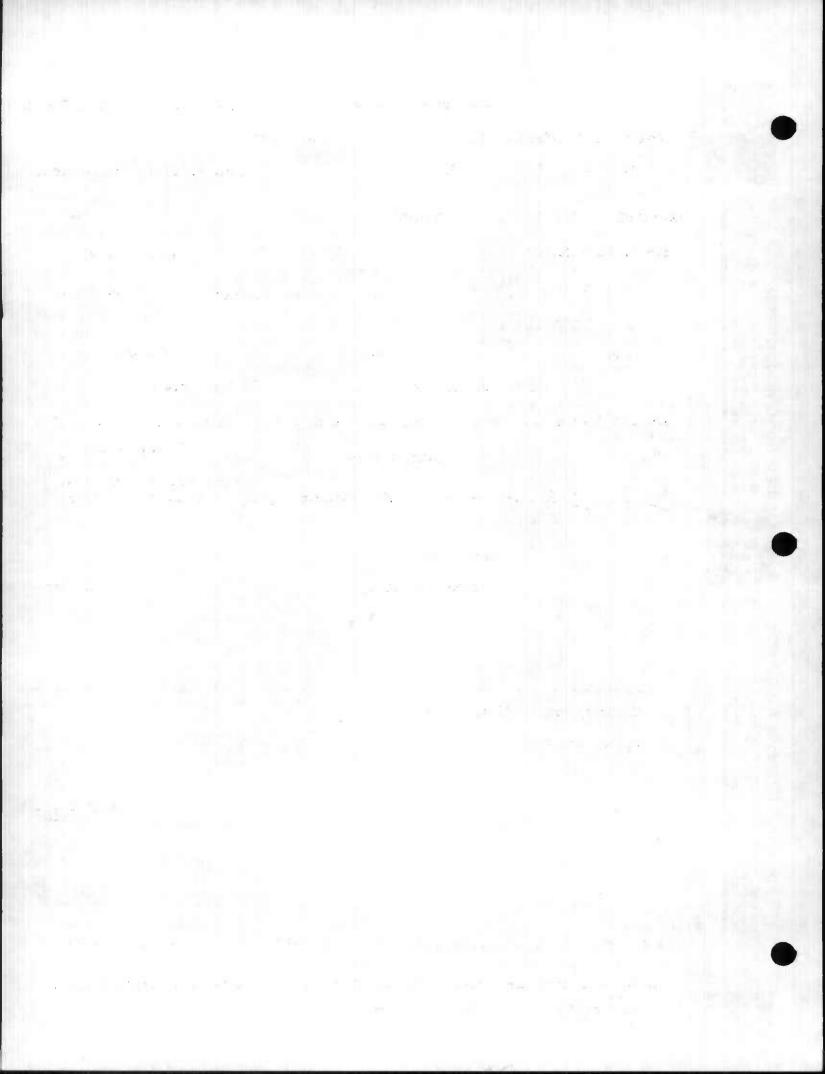
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28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Baltimore, Maryland 21211

29d. Date signed (Month, Dey, Year)

July 13, 1998

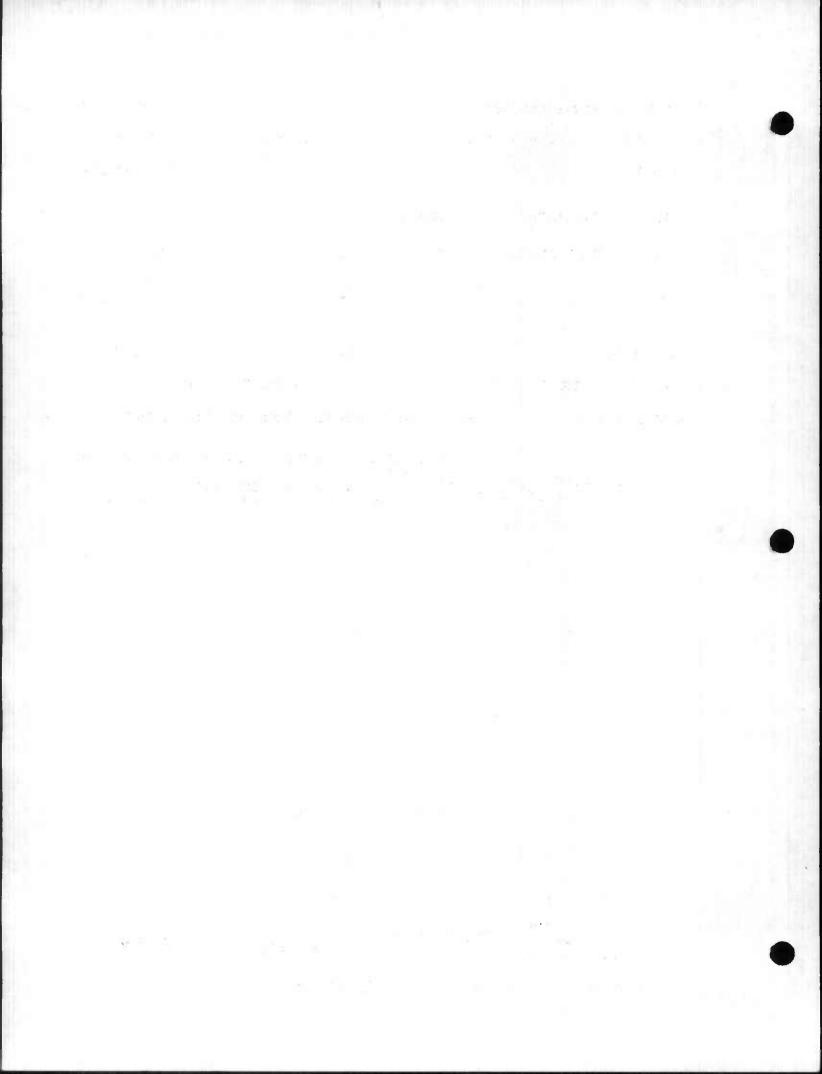


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3 Time of Death Month **Physician** JULY 8:35 P.M. 10 1998 MARGARET HANNA SCHWARTZ /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner GENESIS ELDERCARE TOWSON TOWSON BALTIMORE 5. Social Sacurity Number If Undar 1 Yeer If Under 24 Hrs. 8. Dete of Birth Month, Day, 6/4/05 6 Sex 7. Age (In yrs. iest birthdey) 9. Birthplace (State or Foraign **Funeral** 1 M 2 X F Months Days Hours MARYLAND 93 Yrs. Director 215-01-9357 Usuei Residanca of Dacadani the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yas 2 XNo MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5 21204 Herna 23a 746 CAMBERLEY CIRCLE APT. Al USA death Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No tf Yes, Give Yeer or Datas: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indian, Bleck, Whita, etc. should be filed within 72 hours after of Mental Hyglena. 1 □ Navar Married 2 □ Married altimore. Maryland 21215-0020 "natural", or 1 ☐ Yas 2 ☑ No Specify: Specify: þ 3 Widowed 4 □ Divorcad WHITE Completed 15. Decedent's Education (Specify only highast grada compiated) 16e. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamantery/Secondary (0-12) Collega (1-4or 5+) 8th GRADE HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middia, Maidan Sumama) Be Pagas 1 and 2 should be 1 nent of Haaith and Mental I ant: If Item 27 Is marked of CHARLES J. FIDDES AGNES E. BURLISON 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) NEPHEW 746 CAMBERLEY CIRCLE APT. Al BALTIMORE, MD ROBERT CREANEY 21236 mportant: If Item 27 any injury or other tr 20a. Mathod of Disposition 20b. Placa of Disposition (Name of cematary, crematory or other plece) 20c. Location - City or Town, State 1 □XBuriai 2 □ Cramation 3 □ Ramovel from Stata **Department** BALTIMORE NATIONAL CEM. 7/14/98 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Lisensee 22. Nama and Addrass of Facility JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 np ications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximeta tnterval Between Onset and Deeth **Physician** /Medical Immadiata Causa (Final DRATION diseese or condition rasulting in daath) Examiner Examiner herman physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseasa or injury that initiated avants rasulting in daath) Lest Due to (or es e consequance of): Box 68760. Physician/Medical Dua to (or as e consequence of): attanding 0 P.O. Part II. Other significant conditions contributing to deeth but not rasulting in the undarlying causa givan in Part I. been signed by the s should be datached 23b. Did tobacco use contributs to the cause of death? 1 Yes XINo 3 ☐ Probably 4 ☐ Unknown Records. þ 24b. Wera autopsy findings availabla prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1/A NO certificata 1 🗆 Yas Division of Vital Be Hospital or Attending Physician: director, 25. Was casa refarred to medical axaminar? 26. Place of Death (Check only ona) Othar: Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA this funarai 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury et Work? After Natural 2 Accidant 5 Pending invastigation daath. 1 ☐ Yas 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be datermined 3 Suicide 28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 | Homicida Dertifying Physician: To the best of my knowledge, deeth occurred at tha tima, date end piece, end due to tha causa(s) and mannar as steted.

| Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, death occurred at the time, data and place, and due to the causa(s) end mennar steted. Cal 29a. Certifier To the 29b. Signature and title of Carline 29c. Licansa number 29d. Data signed (Month, Day, Year) Attendina 30. Name and addrass of person who complated causa of daeth (Itam 23a) (Type, Print) Suite 203 4000 Old Court Road Dr. Schwartz Baltimore, MD 31. Deta filed (Month, Day Mear) 1 5 1998 32. Ragistrar's Signatura widon Fundale State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Item 10e Per FH Film G761 7-22-98 rja State of Maryland / Department of Health and Mental Hygiene | Item 31 Per DVR Film G761 7-15-98 rja Item 17,18 per FH Film G761 7-15-98 rja Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3 Time of Death **Physician** Month Veer YINCENT SAVAGE 11211 Jul 92 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
SEPT 25, 1905 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Deys 1**™**M 2□ F 92 215-07-0459 Yrs Director PENNSYLVANIA Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner rount be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 5002 AVOCA AVENUE 21043 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE Specify: þ 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PRESSER TAILOR SHOP 6TH GRADE 18. Mother's Neme (First, Middle, Meiden Sumame)
ONA
UNKNOWN
*5002 AVOCA AVENUE-ELLICOTT CITY, MD 17. Fether's Neme (First, Middle, Last) CHARLES SISAVICIUS - (SON) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ROBERT SAVAGE (SON) 5002 AVOCA AVENUE-ELLICOTT CITY,MD 21043 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 □ Buriel 2 □ Cremetion 3 □ Removel from State LOUDON PARK CEMETERY 7/15/98 BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) er of Fundal Service Licensee 22. Name and Address of Facility
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Interval Between Onset and Death **Physician** /Medicai Immediate Ceuse (Finel disease or condition resulting in deeth) Conystive Heart
Due to (or es e consequence ol):
Valvular Heart Examiner sician and burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last physician s the burial Physician/Medical Due to (or es e consequence of) 80 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detect 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed hes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes case referred to medical exeminer? 28. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28c. Injury at Work? 27. Mennet of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. Medical 29e. Certifier (Check only one)

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Dey, Year)

29b. Signeture end title of certifier

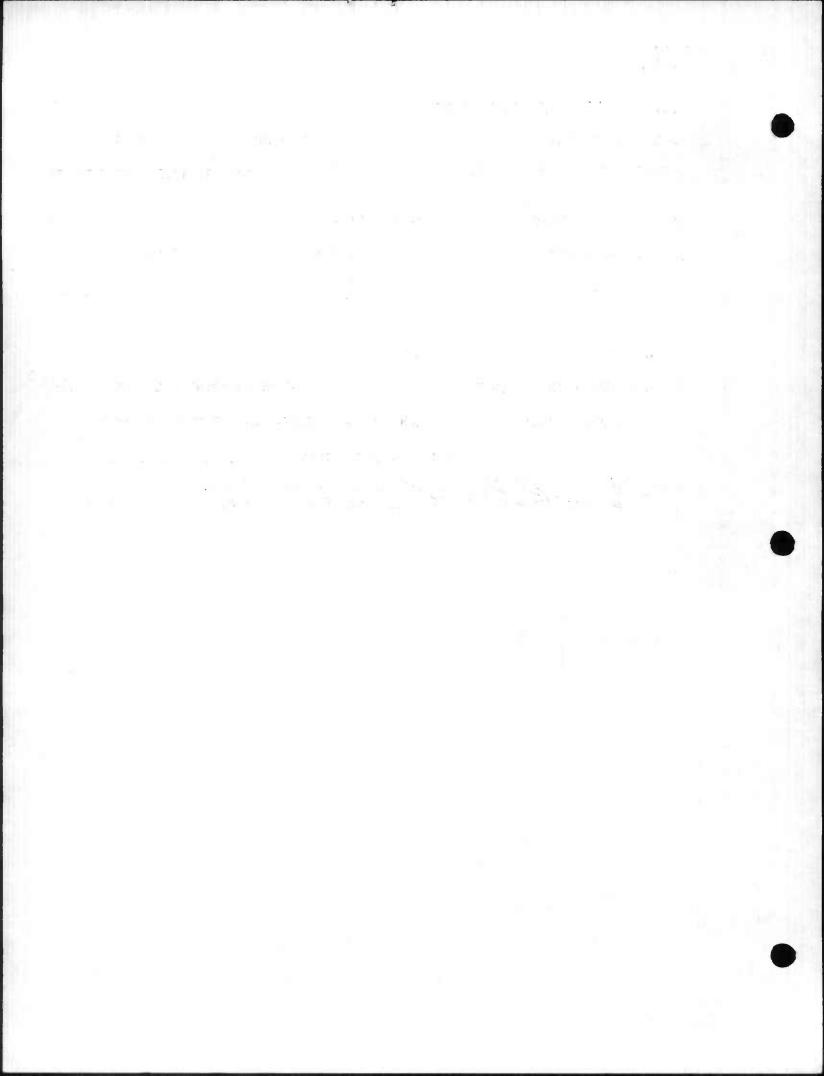
32. Registrer's Signature JUL 151998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Gon- Hory - Early Prt Julia Davidson-Randoll

29d. Dete signed (Month, Day, Year)

29c. License number

D 34520



B.K C

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

Month

1998

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Birthplaca (Stata or Foraign Country)

10d. Insida City Limits

1 ☐ Yas 2 No

D.N.5						S	State of M	Maryla	and / Department of Health and	Mental Hygiene	01700
JOYCE	SMITH	ITEMS:	#23	PART	Ι,	27	PER MEO	G761	and / Department of Health and l 7-22-98 WR Certificate of Death	Reg. No.	61166
	1, [Decedant's N	lama (Fi	irst. Midd	dla. Li	ast)				2. Data of Daath	3. Time of Death

certificate be asscuted ician and buriel-trans physician s the burie 98 9SN for signed by the a peen page 2 director this funeral After death. efter death 6 24 hours Funerel completely

Day Joyce JULY 12, 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL 5. Social Security Number 7. Aga (In vrs. last birthday) **Funeral** Days 1 M 2 F 214-54-6996 48 Yrs. Director DEC. 22, 1949 North Carolina Usual Rasidanca of Dacedani the Marylend 10a. Stata 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Exercises must be nutified at Md. Anne Arundel Glen Burnie Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 104 Foxtrap Drive 21061 Funeral death 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 2 should be filled within 72 hours effer and Mentel Hygiene.
Is marked other than "natural", or fter 1X Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Worker 12 17. Fathar's Nama (First, Middla, Last) Be Will Smith Elsie Locklear 19e. Informent's Neme/Relationship (Type, Print) Sister permit. Pages 1 end 2 st Depertment of Health and Important: If them 27 is n any Injury or other traun Barbara Brecht - Lucabaugh 20b. Placa of Disposition (Name of camatary, cramatory or other placa) Data 20a. Mathod of Disposition 7/14/98 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donetion 5 Other (Specify) Baltimore Washington Crem 22. Nama and Addrass of Fecility 21. Signature of Furneral Service License **Physician** /Medical Immediata Causa (Final **HEMOPRERICARDIUM** disaasa or condition rasulting in deeth) Examiner Due to (or es e consequence of): Examiner RUPTURED MYOCARDIAL INFARCT Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Ceuse (Diseese or Injury that initiated evants rasulting in daath) Last Due to (or as a consequence of): ARTERIOSCLEROTIC? CARDIOVASCULAR DISEASE Box 68760. Physician/Medical Dua to (or as a consaquança of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. p Completed performed? Division of Vital Be 25. Was casa rafarrad to medical axaminar? 26. Piece of Death (Check only ona) XXYas 2 No Certification: To 1 ☐ Inpatiant XX ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 1 X Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be determined 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 3 Suicida 4 Homicida Hospital 624 hours e 29a, Cartifiar (Check only one) Medical within 2 29b. Signature and title of certific 29c. Licansa number

32. Registrar's Signatura

ula Davidson

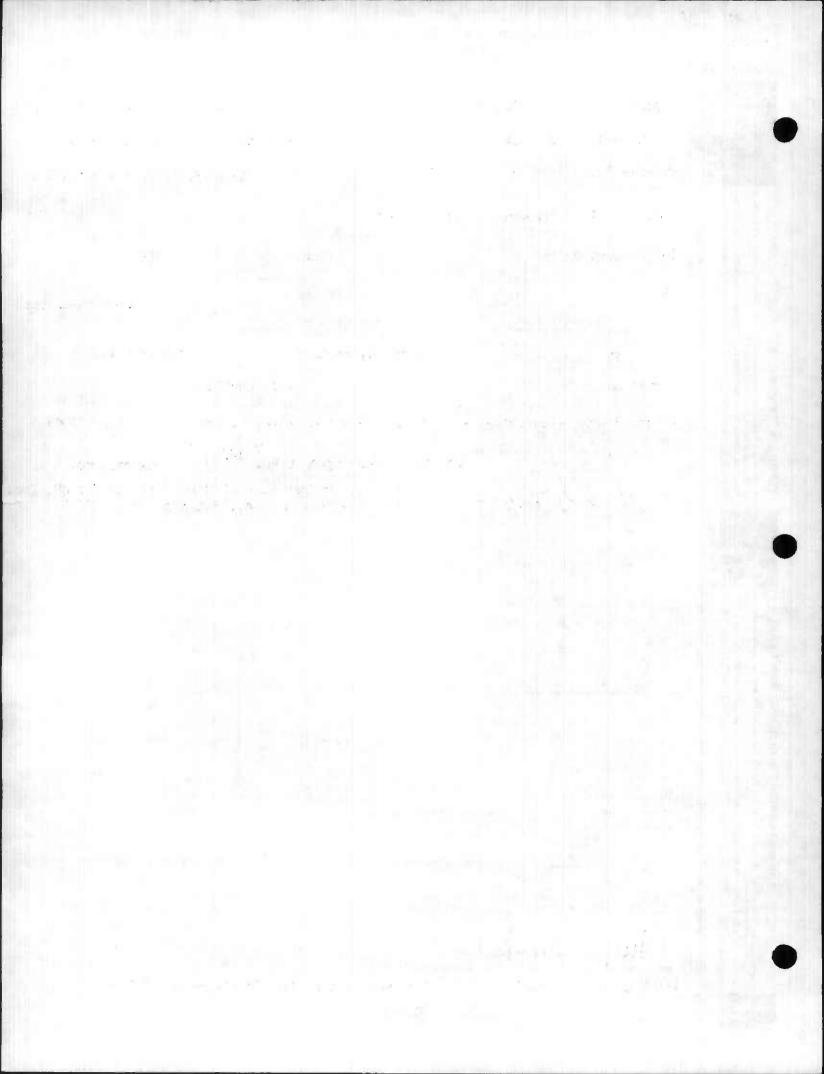
USA 14. Race - American Indian, Black, Whita, atc. Specify: American-India 16b. Kind of Businass/Industry General Motors 18 Mothar's Nema (First, Middle, Maidan Sumama) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 4722 Hale Haven Drive, Ellicott City, Md. 20c. Location - City or Town, Stata Laurel, Md. Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. shock, or heart failure. List only one county on each line. 21075 Approximata Interval Batween Onsat and Death 23b. Did tobecco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of causa of death? 24e. Was an autoosy 1 Yas 2 No Was 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how Injury occurred 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) end menner as stated.

2 Discription Physician: To the best of my knowledge, death occurred at the time, dete and place, and menner as stated.

2 Discription Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the causa(s) and manner stated. 29d. Data signed (Month, Day, Year) 13, 1998 O.C.M.E JULY Ullima 30. Nama and addrass of person who complated causa of daath (Item 23e) (Type, Print) MAMONIO A. Kopul Mr 111 Penn Street, Baltimore, Maryland 21201

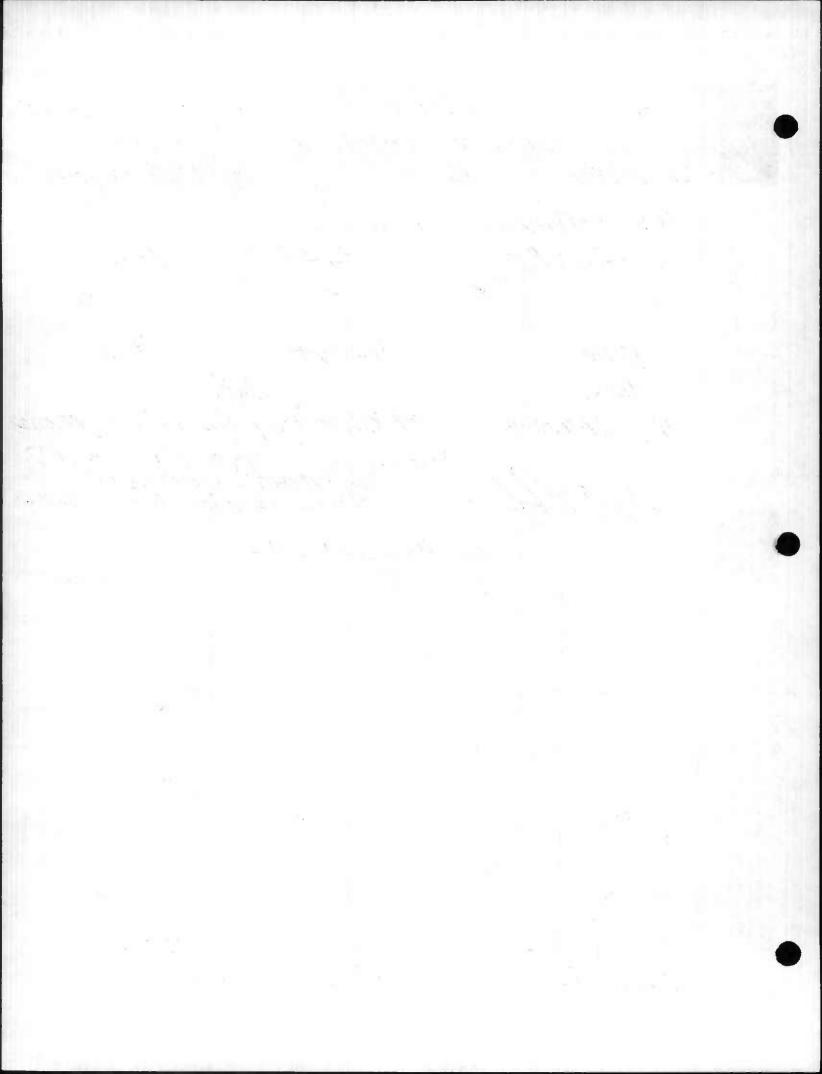
State Registrar 31. Date filed (Month, Day, Yaar)

JUL 151998



State of Maryland / Department of Health and Mental Hygiene

						ite of Death		Reg. No.	21/23	
	Physici /Medi	cal	1. Decedant's Nama (First, Middla, Las	Tuck	er	A Ch Tour	2. Date of De Month	10 1	Yaar 3. Time of Death 998 535 PN	
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	ahow a m		10a. State 10b. County	10c. Cit	y, Town or Location	.,/		0.00	10d. Inside City Limits	
	or 28a-f	Directo	10e. Street and Number	non-	CATONS	to Code		10g. Citizen of W	1 ☐ Yes 2 ☐ NO	
020	filed within 72 hours after deeth with the Maryland Hydione. ther than "natural", or items 23s or 28s-f show int, the Medical Examiner must be notified a	by Funeral Director	11. Maritel Status 1 Never Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedant Ever in U Armed Forcas? 1 ☐ Yas 2 £ If Yas, Giva Yaar or Dates:	If Yas, sp	edant of Hispanic Orlgin? (S ecify Cuban, Maxican, Puar 2 2 No Specify:	Specify Yes or No to Ricen, etc.)	14. Race Bied Specify.	Amarican Indien, k, White, etc.	
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pairimore	permit. Peges 1 Department of H Important: If Iter any Injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	Ramoval from Stata	Placa of Disposition (Nematary, crematory of	76-B	7/19/98	51KP	ODGO MD	
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•	Physician /Medical Examiner	L.	23a. Part Enist the Aséase, or comboned in the Aséase, or comboned in the Aséase, or comboned in the Aséase, or comboned in the Aséase, or comboned in the Aséase, or condition resulting in daath)	Endo	SAN CONSTRUCTION OF AS A CONSSIQUENCE OF	Dund	c or raspiratory a	rrest,	Approximate interval Batween Onset end Death	
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	To the nospital of within 24 hours effect of the Funeral Director Completely filled in b	edicai	29e. Cartifiar (Check only one) 1 Certifying Physical Exami	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wiedga, daath occurre tion and/or invastigation	d at the tima, data and place on, in my opinion, death occu	e, and dua to tha urred at the time,	ceusa(s) and mar date and plece, a	nner es steted. nd dua to tha ceuse(s)	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last, **Physician** 10:05 An 9 1998 4c. County of Death July /Medical 4a Facility Nama (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner BAL 200 If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 217-20-9642 6. Sex ga (In yrs. last birthday) Birthplaca (Stata or Foraign
 Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 D Yrs. Director Usual Rasidence of Dacedant 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 PYas 2 No Directo 7 is marked other than "natural", or items 23s or 28s-f traumetic event, the Medical Examiner must be notifie 10e. Stre et and Number 10f. Zip Coda 10g. Citizan of What Country? Funeral 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 11. Meritel Status 2 12 No 1 Naver Merried 2 Married 1 ☐ Yes 1□ Yes 2₺No Baltimore, Maryland 21215-0020 If Yas, Giva Yaar or Datas: Specify Specify: þ 3 ₩idowed 4 Divorced Completed 16a. Decedant's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be tilled within Department of Health and Mental Hygiene, important, if item 27 is marked other than ". Elamantary/Secondary (0-12) College (1-4or 5+) 1139 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Sumama) Be 341276101 To 19a Informant's Name/Ralationship (Type, Print) al Routa Number, City or Town, Stata, Zip Coda) Addrass (Streat and Number 7, Ball, MD, 2 20c. Location; City or Town, Stata Placa of Disposition comatary, cramatory 20a. Mathod of Disposition 1 DBurial 2 Cremation 3 DRemovel from Stete à 4 Donetion S☐Other (Specify) neral Service Licenses the saar , or comblications that causad the death. Do not an ar Approximete Interval Between Onset end Deeth **Physiclan** /Medical Immed hts Causa (Finat diseasa or condition rasulting In daath) Subarachnoid hours Examiner Dua to (or as a consequence of): 30 Examiner Blood Vews physicien and the burial-tren Sequantially list conditions, if eny, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or es e consequença of) Division of Vital Records, P.O. Box 68760. Physician/Medicai Dua to (or es a consequance of) 88 USB 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. signed by the 3 □ Probably 4 Unknown 1 Yss 2 No þ 24b. Ware autopsy findings aveilable prior to complation of cause of daath? 24a. Was an autopsy Completed has page 2 1 Yas No After this certificate 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatiant funeral 28d. Dascribe how Injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? Data of Injury (Month, Day 5 Panding invastigation 1. Natural 1 Yas 2 No hours after death. 2 Accidant 6 Could not be datarmined 3 T Sulcida 281. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, fectory, office building, atc. (Specify) 4 Homicida 24 hours 29a. Cartifiar (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai completely within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signatura end titla of perill 29c. License number 30. Name and address of person who complated cause of death (Item 934) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

Tillman

JUL 151998

Anthony

31. Data filed (Month, Day, Year)

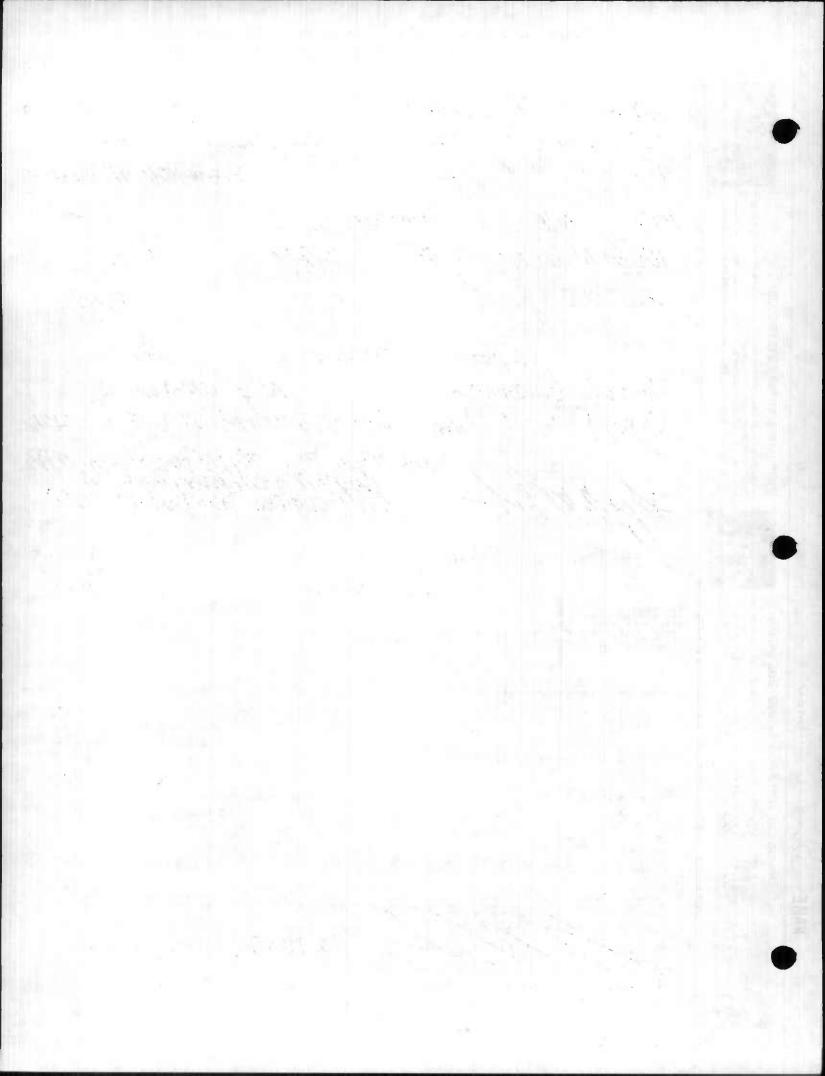
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#7.8.10e.19b per FH G761 7/15/98 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** July : 15 Am homas OHN /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Palmer Home **Baltimore** n/a 5. Social Sacurity Number If Undar 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/110 9. Birthplaca (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1**XX** 2□ F Days Yrs. Director 254-30-9265 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits "natural", or items 23s or 28s-f show XX Yas 2 No Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1352 W. # North Ave. 21217 USA Funerai 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ TOT If Yes, Give Year or Datas: 11 Marital Status Was Decadent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XXX Never Marriad 2 Married 1 ☐ Yes XXNo Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** the Medical 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Peges 1 and 2 should be filed within nent of Health end Mental Hygiene. int: If Item 27 is marked other than ' Iry or other traumatic event, Item Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic B G & E 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) **James** Thomas Sophia McAlpin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry E. Thomas/nephew 5512 Sagra Ave. Balto., MD 21239 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1XXIII 2 Cremation 3 Ramoval from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) King Memorial Park 7/18 Randallstown, MD 21. Surficture of Funeral Service Licensee James A. Morton & Sons Funeral Home Mollon 1701 Laurens St. Balto., 23a. Part1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or lear failure. List only one cause on each line. Approximate Interval Batwaen Onset and Death Physician Caremouna 3 mer /Medical immediate Causa (Final disease or condition resulting in death) **Examiner** Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequenca of): the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 2 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Wara autopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy performed? 1 Yes 2 € No 1 ☐ Yes 2 ☐ No Be 25. Was case refarred to medical examiner? 26. Place of Death (Check only one) Palmer Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Home 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural

P.O. Box 68760, The law requires that the death certificate be signed by the aid be detached for Records. Division of Vital or Attending Physician: this funeral After death. within 24 hours after deat To the Funeral Director: in by t

the Marylend

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

5 Panding investigation

1 Yes 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida

1 critifying Phyafcian: To tha best of my knowledga, death occurred at the time, data and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian (Check only one)

29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

30. Name and address of parson who complated dausa of daath (Itam 28a) (Type, Print) poor

N. Gudaws

31. Date filed (Month, Day, Year) State Registrar

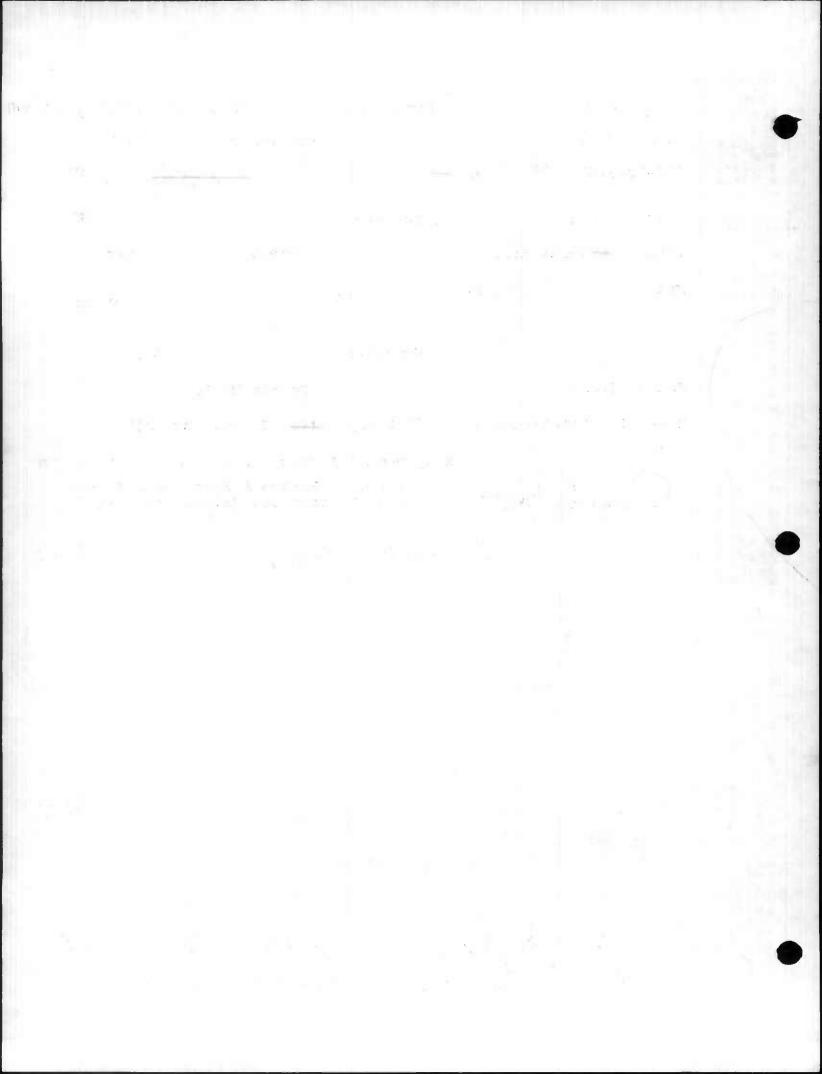
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32. Registre s Signal re JUL 1 5 1998



State of Maryland / Department of Health and Mental Hygiene 🔾

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death JULY **Physician** CORINE THORN TATE 11, 1998 3:35 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner GENESIS CATONSVILLE COMMONS CATONSVILLE BALTIMORE If Under 1 Year Months Days # Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/22/1938 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthpiace (State or Foreign Country)
N. Carolina **Funeral** 1 ☐ M 282 F 59 Yrs. 214-38-2827 Director Usual Residence of Decedent worle 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits I la marked other than "natural", or items 23a or 28a-f ahoo traumatic event, the Medical Examinar must be notified at MD 1) Yes 2 No N/A Director BALTIMORE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3010 Seamon Avenue, #1 238 21225 U.S.A. e filed within 72 hours efter deeth val Hyglene. other than "natural", or items 23 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Reca - American Indien, Bleck. White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo **Black** þ Specify: 3 ☐ Widowed 4 ☐ Divorced Yeer or Datas: Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Internal Revenue College (1-4or 5+) Management Assistant 12th permit. Peges 1 and 2 should be filed.
Department of Heelth and Mental Hygi important: If frem 27 is marked other any injury or other traumers. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Paul Vester Thorn, Sr. Sarah Jane Johnson 10 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 2420 Callow Avenue, Balto., MD Michelle Tate White 20b. Pieca of Disposition (Neme of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removel from State Cedar Hill Cemetery 7/18/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Lit LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock; or fleart failure. Little by one cause on each one. **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical Examiner Large lifeted sarral decistus

Due to (or as a consequenca ot):

Hente Cerebro vare ular accident. Examiner ician and burial-transit thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last physician the buria Box 68760. Physician/Medical Due to (or as a consequenca of): 950 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Hypertension 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 2 The law requires Capeter mollitus 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was casa raferred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To After this funeral 27. Manner of Death 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Panding investigation 1 Natural 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida Placa of Injury - At home, farm, street, factory, offica building, etc. (Spacify) in by 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

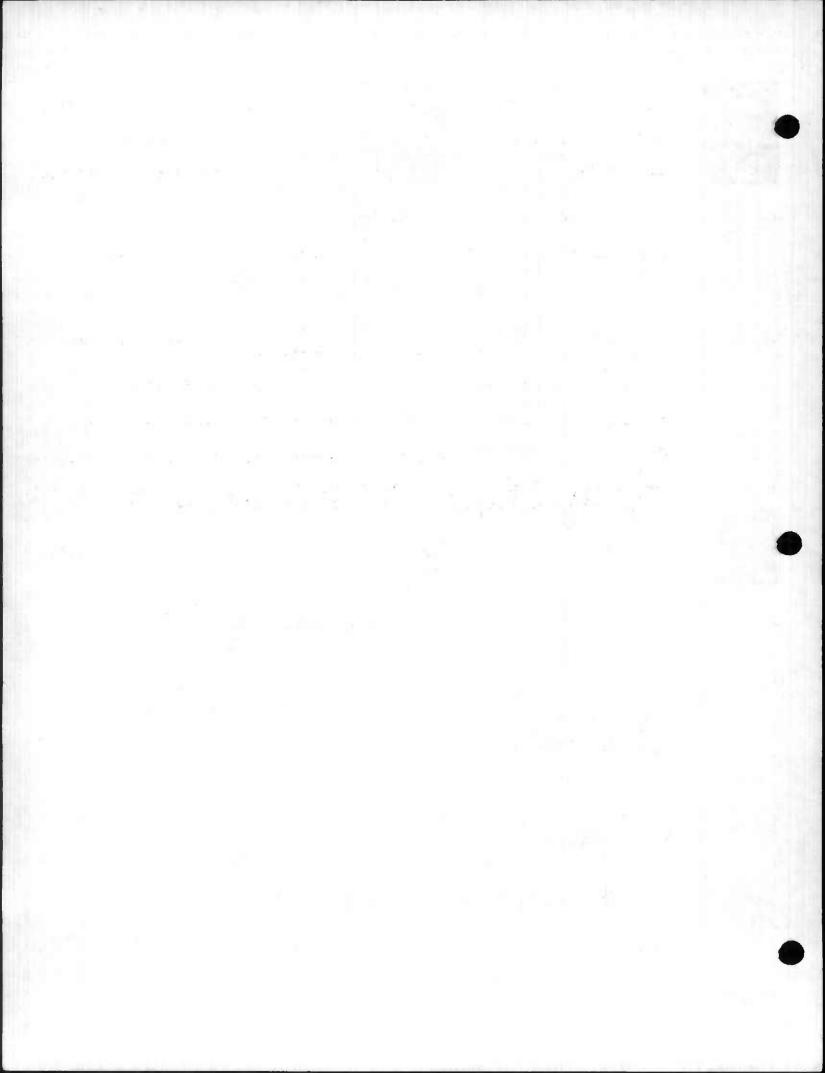
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Typa, Print) Rd Bulleinon MD-2122 0 4367 a RAJA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

while Davidson-Randalla

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Registrar

JUL 151998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Month Yaer **Physician** HOWARD ROBERT THOMAS JULY 9 1998 6:50 P.M. /Medical 4e. Facility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE CITY N/A Under 24 Hrs. 5. Social Security Number If Under 1 Year Months Days 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1XM 2□ F Yrs. Director 220-18-6109 72 12/6/25 MARYLAND Usual Rasidance of Dacadani the Meryland 10e State 10h County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director n/a BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6715 GLENKIRK ROAD 21239 Funeral USA death 12. Was Decedant Ever in U,S. Armed Forcas? 1 [x] Yas 2 □ No If Yas, Giva Yaar or Detas: 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indien, Black, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hydine. Important: If item 27 is marked other than "natural", or file any injury or other traumatic event, the Medical Examples. 1 □ Navar Married 2 1 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: by Specify 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decadant's Education 16b. Kind of Business/Industry (Specify only highest grada completed) Elamantary/Secondery (0-12) College (1-4or 5+) CHIEF CLERK CHESSIE SYSTEM 17. Fether's Nema (First, Middla, Last) 18. Mothar's Name (First, Middla, Maldan Sumama) Be JOHN BARTHOLOMEW THOMAS MARIE MATILDA BURKHARDT 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) EDNA E. THOMAS WIFE 6715 GLENKIRK ROAD BALTIMORE, MD 21239 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - Cify or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 7/13/98 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility JOHNSON FUNERAL HOME, P.A. domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, only one cause on each line. 21286 Approximata Interval Between Onset end Death **Physician** Cardiac Arrest /Medical Immediete Causa (Final diseese or condition rasulting in death) Examiner Examiner burial-transit Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Disaase or Injury that Initiated avents rasulting in daath) Lest Dua to (or as a consequence of) and nding physician a use as the burial-Box 68760, requires that the death certificate be Physician/Medical rerarderasi's atten Por P.O. signed by the signed to be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Ware eutopsy findings available prior to page 2 should Completed 24a. Was an autopsy performed? Deen completion of cause of death? The law has certificete 2 0 NO 1 Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this certifica completaly filled in by the funeral director, t 25. Was casa rafarred to medical Be 26. Placa of Death (Check only ona) axaminar? Hospital: Other: 4□ Nursing Homa 5□ Rasidanca 6 □Other (Specify) 5 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Daath 28a. Data of Injury (Month, Day Yaar) Medical Certification: 28b Time of 28d. Dascribe how Injury occurred 28c. Injury et Work? 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicida 28a. Placa of injury - At homa, ferm, streat, factory, offica building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta and piace, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha time, deta and piace, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Yaar) dans mo

State Registrar

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30. Nama and eddrass of person who complated cause of death (Item 23e) (Type

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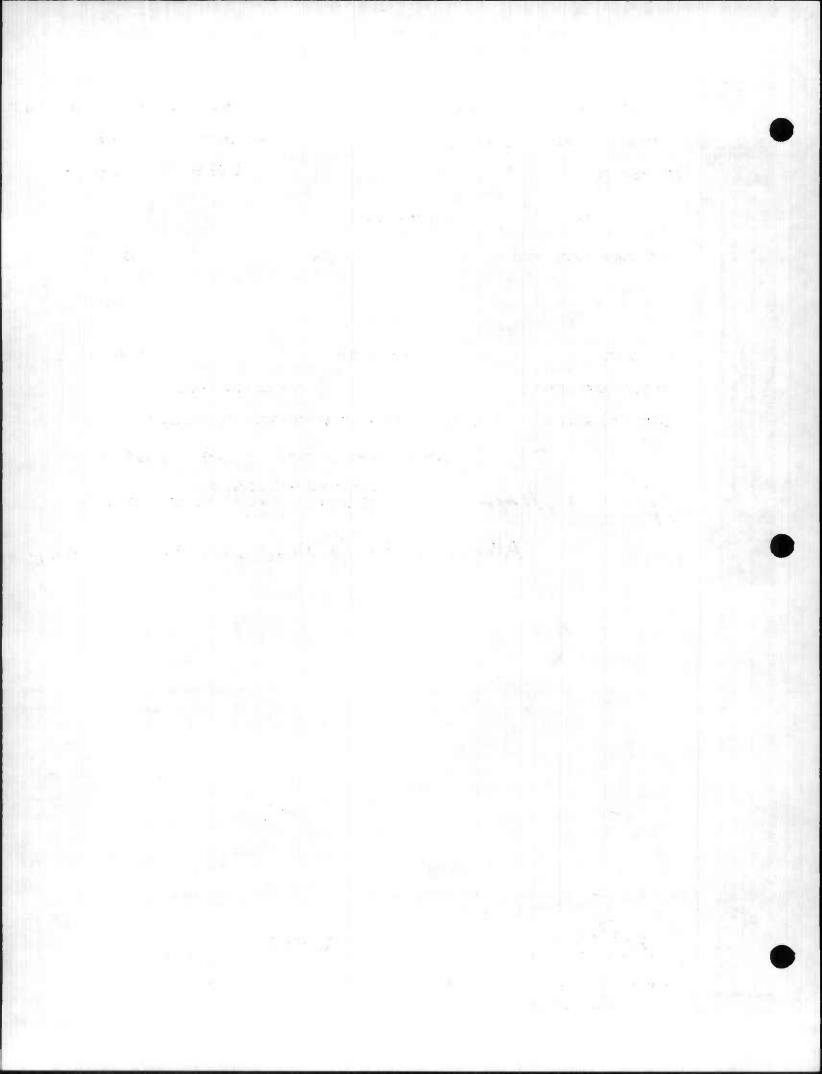
Cardina Ariest Congestie Heart Failure Hypertens:co Otherselors

12327,

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month Year **Physician** 11 10:00 P.M. PAULINE ELIZABETH THOMAS JULY 1998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) **Examiner** BALTIMORE CITY GENESIS ELDERCARE LONGGREEN N/A 8. Dete of Birth (Month, Day Year) 3/28/93 if Under 1 Yeer if Under 24 Hrs. 5. Sociel Security Number 7. Age (In vrs. lest birthdev) Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 2 1 F Hours 105 Director 218-32-0028 MARYLAND Usuet Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "naturef", or flems 23s or 28s-f show the Medical Examiner must be noutled at 1 Yes 2 □ No Director N/A BALTIMORE CITY MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21239 Funeral 1121 RAMBLEWOOD ROAD APT. USA death 14. Raca - American indien, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours effer. Department of Health and Mental Hygiene. If item 27 Is marked other than "naturef", or ite ☐ Yes 2 No 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No It Yes. Give Specify: Specify: 2 3 Widowed 4 Divorced WHITE Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Etementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 6th GRADE traumetic event. 17 Fether's Neme (First Middle Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be WILLIAM G. SHERWOOD CAROLYN M. MYERS 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) DAUGHTER 1121 RAMBLEWOOD ROAD BALTIMORE, MD MYRTLE G. MARKLAND other 20b. Plece of Disposition (Neme of cometery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriet 2X Cremetion 3 ☐ Removel from State injury or METRO CREMATORY, INC. 7/15/98 CATONSVILLE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture Al Funerel Service Licensee 22. Name and Address of Facility JOHNSON FUNERAL HOME, P.A. Mu ayon 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part. Enter the disease, or complications het caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervat Between Onset end Deeth **Physician** Cardiovas wlar Disease Atherosclerotic /Medical tmmediete Ceuse (Finel 40 415 disease or condition resulting in death) Examiner Examiner physician and the bunal-transit certificate be executed Sequentietly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca ot): Box 68760 Physician/Medical Due to (or es e consequence oi): Se 950 6 23b. Did tobacco use contribute to the cause of death? P.0. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 8 signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy tindings evelleble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? page 2 1 Yes 2 ₩ 1 Yes 2PTNo certificate Attending Physician: director Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this funeral 28c. Injury at Work? 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Neturel 5 Pending after death. Director: Aft investigetion 2 Accident 6 Could not be determined 3 Suicide Placa of Injury - At home, term, street, fectory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 - Homicide ò To the Hospital c within 24 hours at To the Funeral Di 29e. Certifier 1 Cartifying Physicien: To the best of my knowtedge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted. Medical (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. 29b. Signeture and Mool certilier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 4300 North Charles St. Baltimore MO IMD 32. Registrars Signature
Sima Daydson-Randall State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 13 1998 Physician JULY 8:35AM CAROLINE J. TESAR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner TOWSON BALTIMORE HOLLY HILL MANOR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Houra 1 ■ M 2 X F Yrs. 212-32-1009 89 12-14-1908 MARYLAND **Director** Usual Residence of Decedent the Merylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits than "naturel", or items 23e or 28a-f show the Medical Examinar must be notified at 1 ☐ Yea 2 € No Director MD BALTIMORE TOWSON 10f. Zlp Code 10g. Citizen of What Country? 10e. Street and Number 531 STEVENSON LANE 21204 USA death \ Funeral 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 and 2 should be filled within 72 hours efter Health and Mantal Hygiene. 5m 27 is marked other than "natural", or ite 1 Yes 2 No If Yas, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Àq 3 Widowed 4 Divorced WHITE Completed 16e. Decedent's Usuai Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT usa ratired) I Hygiene. Eiamentary/Secondary (0-12) College (1-4or 5+) 2YRS ADMINISTATIVE ASSISTANT SHEPHERD PRATT traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) JOSEPH F. TESAR JOSEPHINE SKRABEK 19b. Malting Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health e important: If item 27 is any injury or other tra EMANUEL J. PICEK (NEPHEW) 4707 RUBY AVE. BALTO., MD. 21227. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MORELAND MEM. PARK BALTO., MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximata tntervat Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medicai ALZHeimers 124195 Examiner Due to (or as a consequence of): Examiner certificate be executed physicien and the burial-trans Sequantially tist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): 98 use ō 23b. Did tobacco use contributa to the causa of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, P. py 50 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy Completed page 2 hes 1 Yes 2ETNo 1 Yea certificate or Attending Physicien: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only ona) Hospitai: Other:

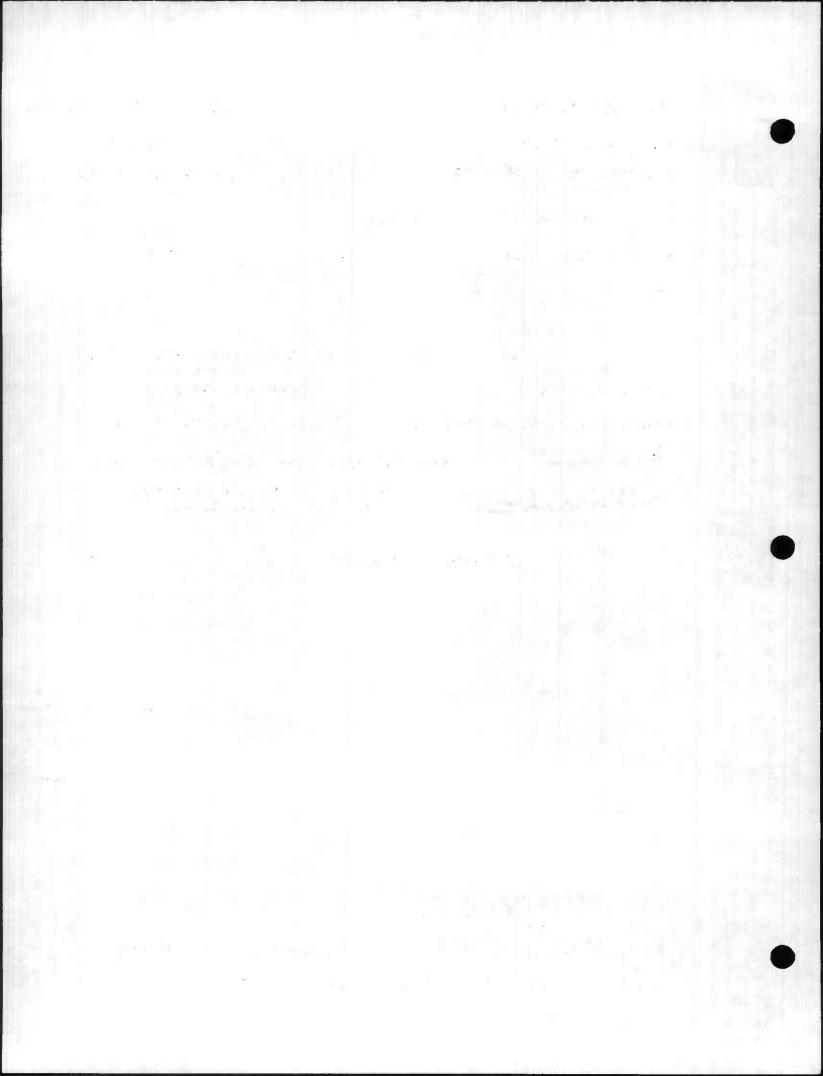
AD Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yas 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pendina 1 ☐ Yas 2 ☐ No death. investigation 2 Accident after death 6 Could not be detarmined 3 ☐ Sulcide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 12 Certifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. edical 29a. Certifiar within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. To the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature end title of cartifial. Deane w 720673 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) GEORGE LOWE M.D. 7672 BELAIR RD. BALTO., MD. 21236. 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State

Registrar

JUL 151998

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DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth July **Physician** 10:10 A.M. Theresa 1998 Voir /Medical 4a. Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Atlantic General Hospital Berlin Worcester ff Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Jan. 1, 19 11/15-7/12/98 2210 5. Social Security Number If Under 1 Year 9. Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Days Director 215-52-4707 83 Yrs. Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. inside City Limits ortant: if item 27 is marked other than "natural", or itams 23a or 28a-f show injury or other traumatic event, the Modical Examiner must be notified at 1X Yes 2 No Directo Maryland Baltimore. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4320 Clare Way 21213 U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry nd Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home. 5th Grade 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Raniero Fusco Alexandria Paleschi Department of Health end important: If Item 27 is ma any injury or are 19a. Informant's Name/Ralationship (Type, Print) [Grand | 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) dghtr | 5917 Powellville Road, Willards, Maryland 21874 Charlene D. Elliott-Carr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 7/16/98 Baltimore, Maryland 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Fecility Schimunek Funeral Home Inc. 23a. Parl 1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart failura. List only one cause on each line. **Physician** CONGESTIVE HEART FAICURE /Medical Immediata Causa (Final diseese or condition resulting in death) **Examiner** Due to (or as a consequence of):
THEND SCIENDTIC CANDIOVASCULAR DISENSE Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Physician/Medical Dua to (or as a consequenca of): P.O. Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use pontribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, b 24b. Wara autopsy findings eveileble prior to 24a. Was an autopsy performed? Completed completion of cause of death? certificate has 20 No 1 Yes 1 Yes 2 No Division of Vital Hospital or Attanding Physician: 24 hours efter death. Funeral Director: After this certifica 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Panding invastigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicida To the Hospital of within 24 hours e To the Funeral D Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian Medical npletely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1046257 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Healthway UKine

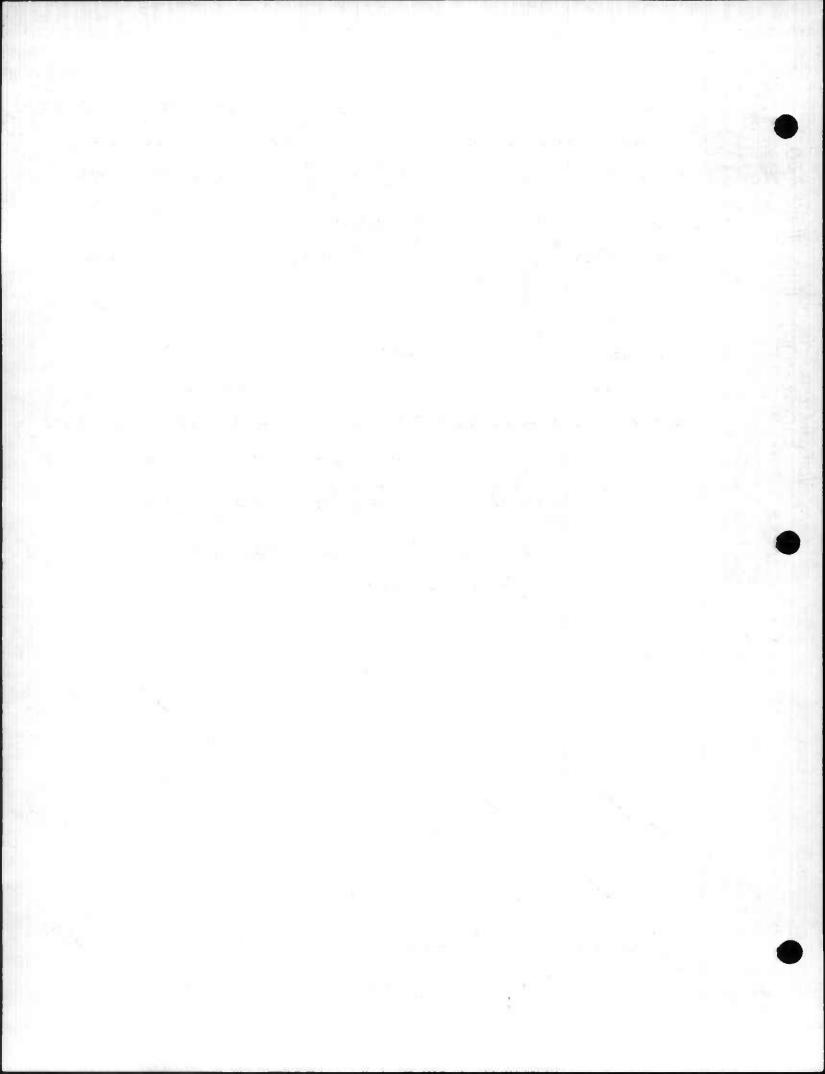
38. Ragistrar's Signature BENIN, MD 21811

whie Nevidon Pandall

State Registrar

31. Date filad (Month, Day, Year)

JUL 1 5 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death MARY WAINWRIGHT EMMA 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death ENLUC BALTOI If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) 1□M 200 F Months 216-36-0989 Days Hours Min 80 Usual Rasidence of Dacedant 10c. City, Town or Location 10b. County 10d. Insida City Limits Ballo Ma WYas 2□ No 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? Rd. U.D. H 212 12. Was Decedant Evar in U,S. Armed Forces? 1 Yas 2 No If Yas, Give 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amaricen Indian. 1 Navar Married 2 Married Black 1□ Yas 2 No Specify: 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry JeH Collega (1-4or 5+) Houseme 12 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Malden Sumama) CHARLES KeddING SARAL WOFM. AI 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Berger (Dangeller Ballo eNLucey Rd 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition 1 Burlal 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) edar 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one cause on each line. Locks xocks Approximata Interval Between Onsat and Death Immediata Cause (Final disease or condition resulting in death) 40005 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Heart 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Fracture 1 Yas ZONO 1 Yas 25. Was casa rafarred to medical axaminar? 28. Place of Death (Check only ona) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 1 Inpatiant 2 ER/Outpatient 3 DOA 5 Rasidence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

Director

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Funeral

Director

Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at

pernit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is merked other than any Injury or other traumatic event, the Magnita.

filed within 72 hours efter death with the Maryland

attending physician and for usa es tha burial-transit the signed by s need cartificate hes

The law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Inneral

Physician/Medical Examiner þ Completed Be P 27. Mannar of Death Certification:

Medical

1 Accident

3 ☐ Suicida

29a. Certifian

4 Homicide

(Check only one)

31. Data filed (Month, Day, Year)

or Attending Physician: within 24 hours after death. To the Funerel Director: After this To the Fune complately f

> State Registrar

29b. Signature and titla of certifiar

5 Panding Invastigation

6 Could not be determined

JUL 151998

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28b. Tima of

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28a. Data of Injury (Month, Day Year)

29c. Licansa number D 4 1 4 8 6

1 Yes

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Dascribe how Injury occurred

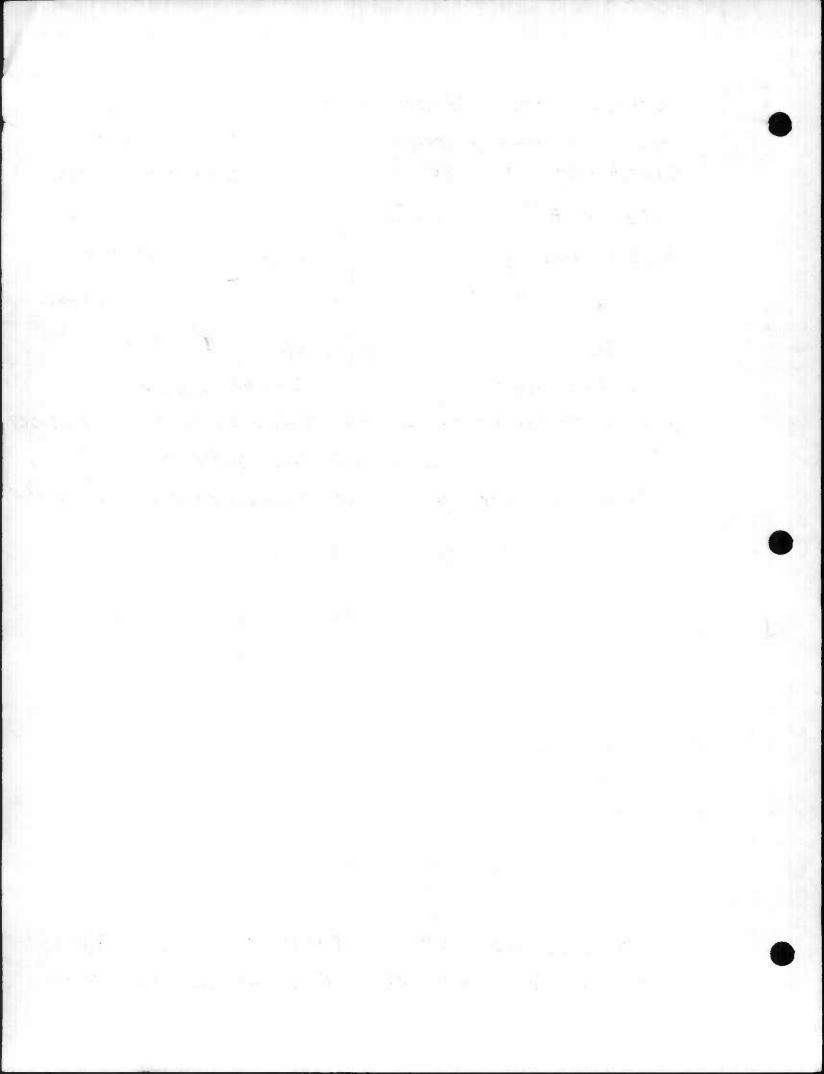
29d. Data signed (Month, Day, Year)

30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print)

720 Rutland Ave.

32. Registrar's Signatura

Fulla Duvidson-Randale



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death 11:40 am Annette Wheatley Helen JILL 4b. City, Town, or Location of D 4a_Facility Neme (If not institution, give street and number) 4c. County of Deeth 405e Laxe If Under 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) Months Deys Hours 1 M 2 F Yrs. 220 09 4784 80 April 9, 1918 Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Essex 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1 Brett Court Apt 108 21221 USA 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Meritel Status Bieck, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuei Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 Agent Real Estate 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Schleicher Henry Catherine Foote 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Linda Waggoner (daughter) 210 Carrol Island Road Middle River, Maryland 21221 20b. Piece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Belair Memorial Gardens 7/15/1998 Belair Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funera Service Licensee Bruzdzinski Funeral Home PA 1407 Old eastern Avenue Essex, Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest or heart failure. List only one cause on each line. Approximete Intervei Between Onset end Death immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or es a consequence of): 23b. Dtd tobacco use contributs to the cause of death? Pert II. Other stanfftcant conditions contributing to death but not resulting in the underlying cause given In Pert I. 2 No 1 Yss 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en autopsy 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 22 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Yeer) 27. Menger of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 Yes 2 No investigetion 2 Accident 3 Suicide

/Medical Examiner physician and the burial-transit law requires that the death certificate be executed Box 68760 for use es 98 USB ed by the a Division of Vital Records, P.O. signed by t d be detech peed has The The certificate Physician: this After or Attending death. Director: within 24 hours after To the Funeral Dir completely filled in

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29a. Certifier

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6 Could not be 4 ☐ Homicide

28e. Pieca of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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2 Madical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture and title of cartifier

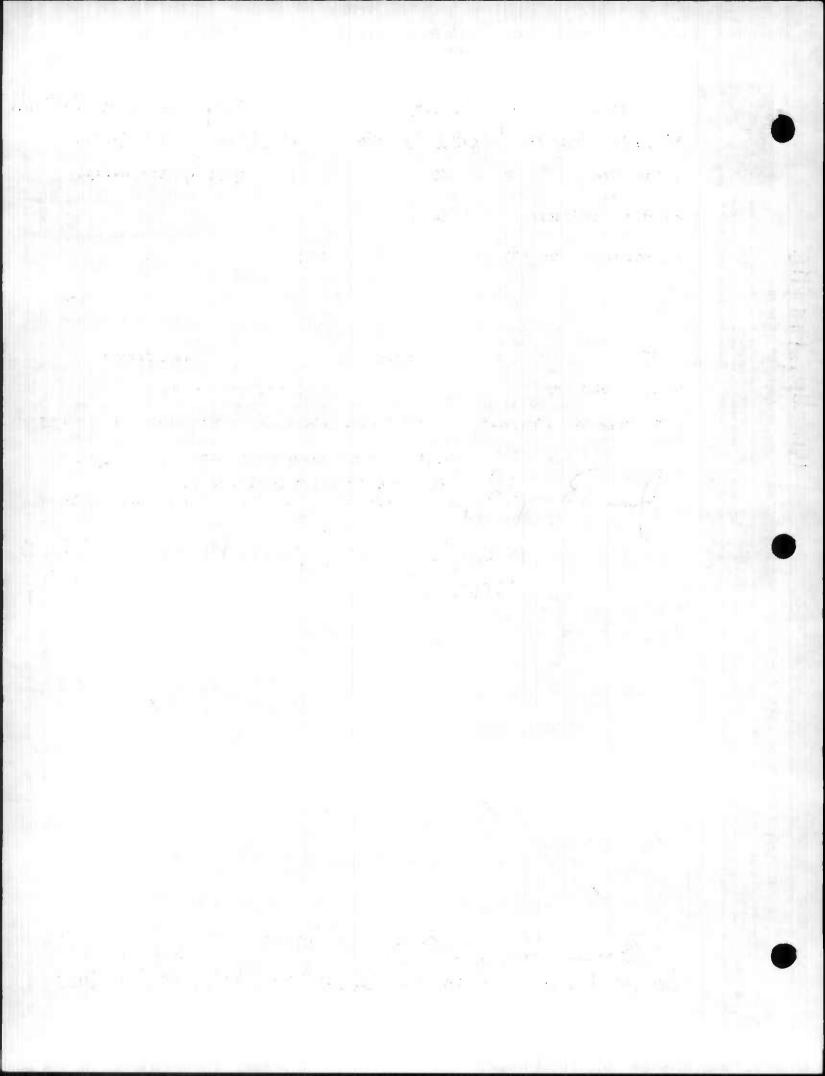
29c. License number

29d. Date signed (Month, Dey, Year)

30-Neme end address of person (Type, Pript

32. Registrar's Signeture

State Registrar

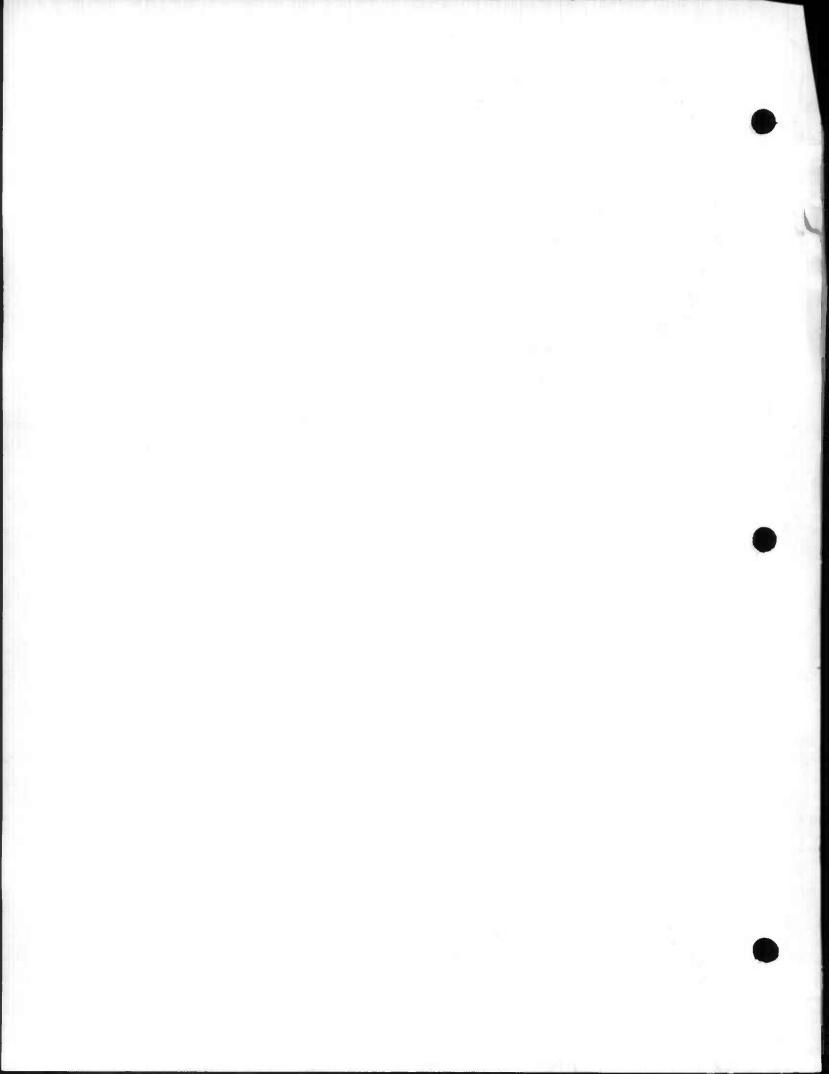


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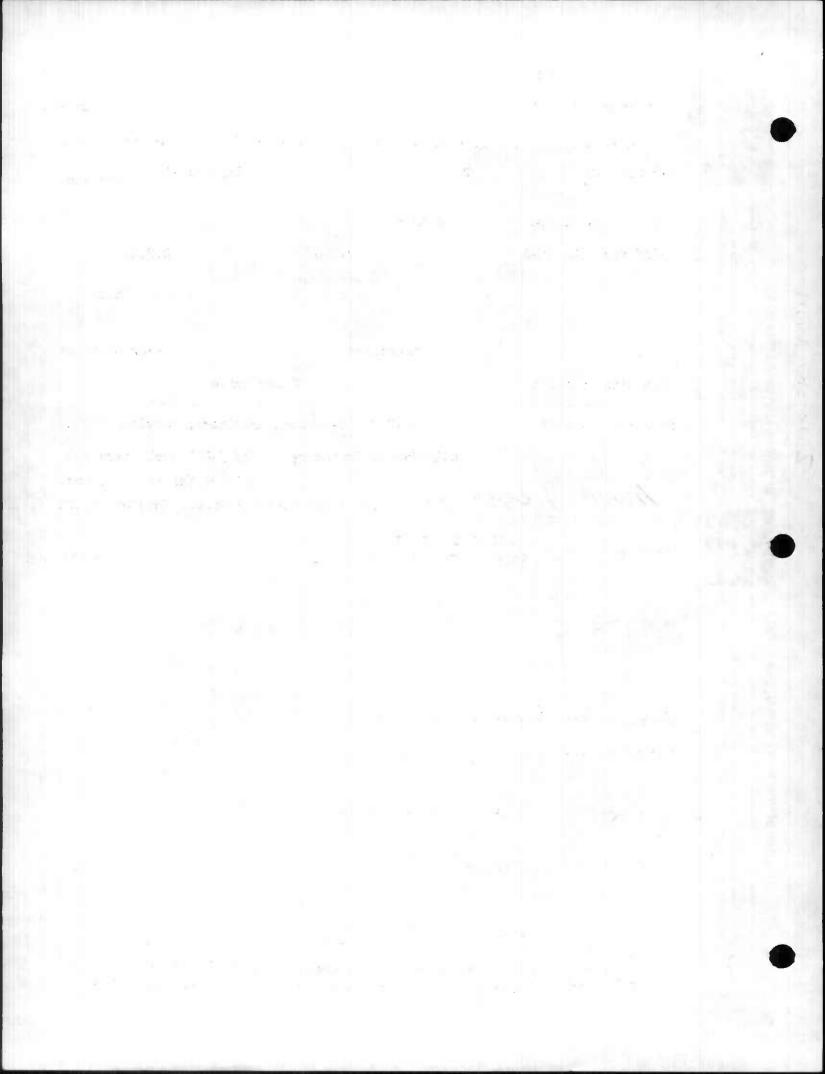
	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
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ALTIMORE, death. Page 6 may be tuneral director, page i. examiner must be		N. 101.	2/2					Y W. J		INS &	SONS	s co		
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E E		23. PART I. Enter the diseases, or shock, or heart fellure.	complications that List only one cause	caused tha de e on each line	eath. Do	not enter th	ne mo	de of dying, su	ich aa ci	erdiac or reap	iratory an	reat,	Approximata Interval Bstween	
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DIVISION TO THE HOSPITAL DR ATTENDING P TO THE FUNERAL DIRECTOR: After the Be filed within 72 hours after death IMPORTANT: If item 28 is mart	COMPLETED	29a, CERTIFIER CERTIFYING PUYE	CIAN. To the best of							-		_		
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	s 1 end f Health Item 27 other tr	Lorraine Zalenski						Road	d Bal	ltimore					
ore	Pages 1 nent of H nt: If iten iry or oth	20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or T													
altimore,	ment:	4 Donetion 5 Other (Specify) Balto/Wash. Crematory //2/98 Laurel, Maryland													
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ono	Attending P or death. Sctor: After I by the funeral or:	27. Menner of Deeth 1 X Naturel 5 Pending 2 Accident investigation	28e. Dete of Inj (Month, De		8b. Time of Injury	M 2	8c. fnjur Wor 1 □	yet k? Yes 2□	No	28d. Describ	e how injury	occurred			
Division	tal or Attending P is after death. In Director: After ted in by the funers Certification:	3 Suicide 6 Could not be determined								28f. Location (Street end Number or Rurel Route Num City or Town, Stete)					
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DHMH 16 Rev 6/95

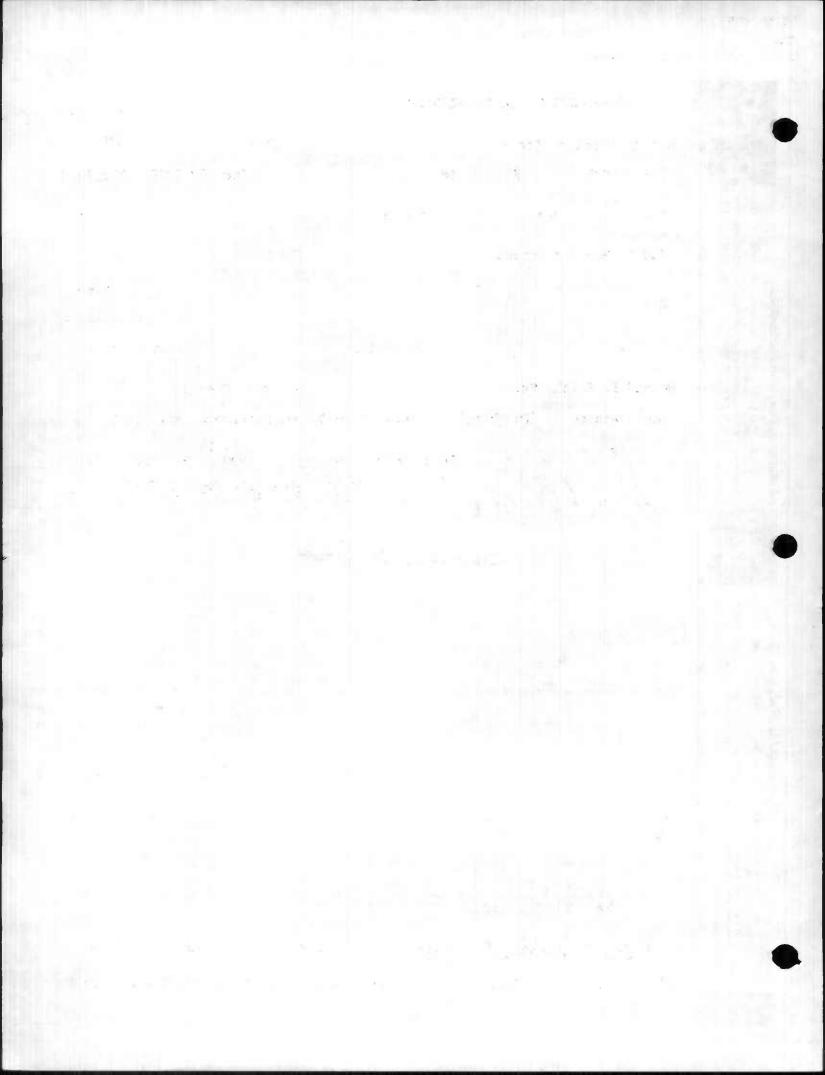


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iiiiiei	1629 5	Hanove	r Stre	et					Balti	more			N/A	
ral	5. Social Security		6. Sex	7. Age	(In yrs. le	ast birthday)	If Under 1 Months	Year	If Under 24 H	Irs. 8 Det	te of Birth	Year)		place (State or Foreign
tor	216-54-		1□ M 2	X	48	Yrs.		,-				1949		yland
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by Funeral Director	Md.		n/a	ŀ	Ba1	timore	9							1▼ Yes 2□ No
Director	10e. Street end N	lumber					10f. Zip C	Code			10	0g. Citizen o	f What Cour	ntry?
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	23a. Pen 1. Enter shock, or he	r the diseese, or eart failure. List	complication only one cau	s that caused se on each lin	the death	. Do not ent							Md.	
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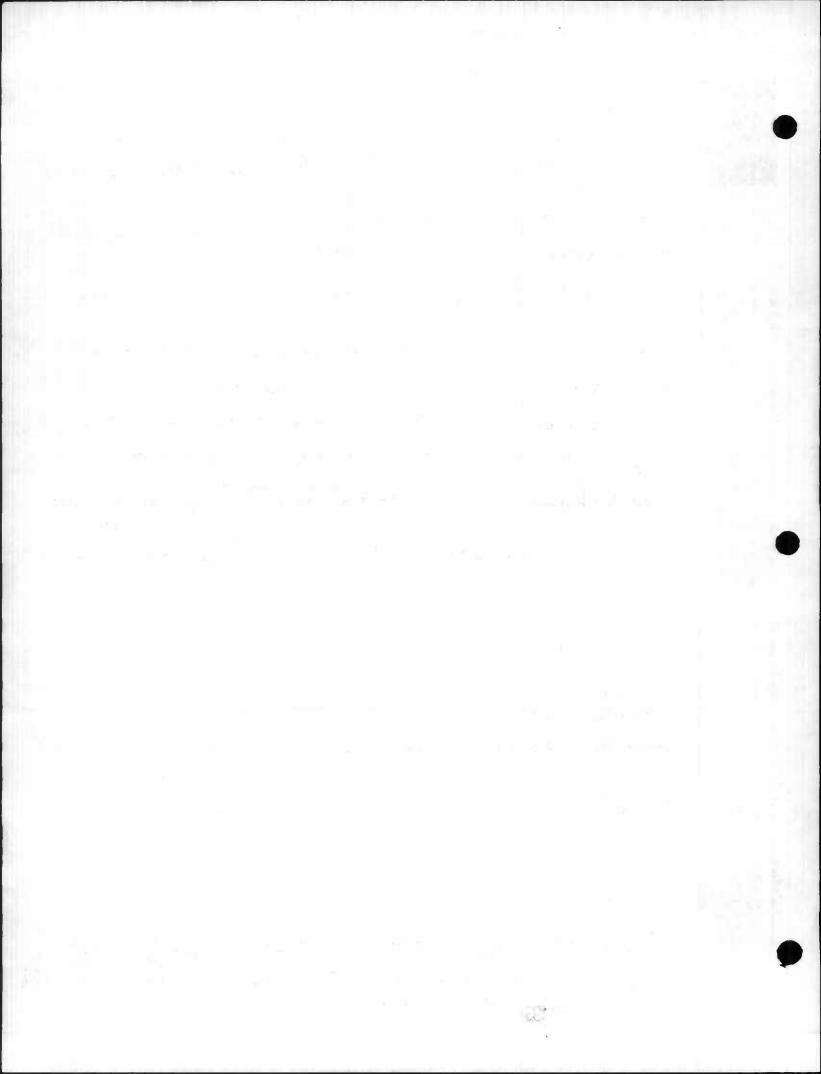
State Registrar 31. Date filed (Month, Dey, Year)
JUL 151998

B. Konsu 111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene 8 2 1 7 3 6

						Ce	rtificate of	f Death			Reg. No.		1 100	
П			1. Decedent's Name (First, Middle, La	st)						2. Date of De	ath		3. Time of D	Death
	Physic /Medi		George Mar	tin B	aker					Month July	4 . 19	Year 998	3:00	PM
ı	Exami		4a. Facility Name (If not institution, giv					4b. City, To	own, or Lo	ocation of Deati		nty of Death		1 11
1			112 Mimosa Dr:	ive				Caml	bridg	ge	Do	chest	cer	
r	Funeral		Social Security Number 6. S	ex. DAM 2□ F	7. Aga (In yrs.	last birthday)	If Undar 1 Yea		24 Hrs.	8. Data of Bir	th	9. Birth	placa (State or	<i>Foreig</i> n
L	Director		154-05-6186 Usual Residence of Decedent	□ M 2□ F	81	Yrs.	Months Days	s Hours	Min.	8. Data of Bir Jan 30	,1917	Nev	Jerse	у
	how		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation						10d. Inside City	
	e Me	ctor	Maryland Dorche	ster		Cambri	dge						1 ☐ Yes	No Kill
	1 th	Director	10e. Street and Number				10f. Zip Code				10g. Citizen o	of What Cou	intry?	
	15 w 15 m		112 Mimosa Drive				2161	.3			1	US		
	r dea	Funeral	11. Marital Status	12. Was Dece Armed For			Was Decedant of	Hispanic Or	lgin? (Sp	ecify Yas or No Rican, etc.)		ace - Amer	icen Indian,	
Baltimore, Maryland 21215-0020	filed within 72 hours after death with the Maryland Hygiene. *natural*, or flems 23a or 28a-f show int, the Medical Examera must be notified at	by	1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced	1XXYes If Yes, Give Year or Da	2 □ No		1 □ Yes 2 X XN			, iloan, olon,	Spec		nițe	
5-0	72 h netu	Completed	15. Decedent'a Ed (Specify only highest gra	lucation de completed)		16a. Dece	dent's Usual Occi	upation e durina mos	st of work	ina	16b. Kind of	Business/li	ndustry	
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Inc	m 0 -	Be	17. Father's Name (First, Middle, Last,					101		e (First, Middle,	, Maiden Sum	ame)		
Y	2 should be and Mentel is marked or raumatic eve	2	George Baker					Ma	abel	Perry	P111-			
Jar			19a. Informant's Name/Relationship (19b. Maili	ng Address (Stree	et and Numb	er or Run	al Route Numb	er, City or Tox	vn, State, Zi	ip Code)	
6	Health Health om 27		Margaret H. Bake	r Wif			Mimosa I		Camb:		-			
0	H ite		20a. Method of Disposition XXX Burial 2 ☐ Cremation 3 ☐	Ramoval from S			osition (Name of matory or other pi		į.	Date	20c. Locatio	-		
tim	Per timen tant:		4 ☐ Donation 5 ☐ Other (Specific	1)	MD	Veter	ans Ceme	etery	1	7/8/98	Hurlo	ck, Ma	aryland	
Sal	permit. Peges 1 and 2 Department of Health of Important: If Item 27 It any Injury or other tra		21. Signature of Funeral Service Licer	see			2. Nama and Add homas Fu			o D A				
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	-		23a. Part. Enter the disease, or com	plications that ca	used the deat								Approximate Interval Between	een.
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П	LAAIIIIICI		rasulting In death)	α		or as a consec								
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	ecute and -trans	Examiner	Sequentially list conditions,	0. —	Due to (c	r as a consec	quenca of):					1		
30,	sian surial		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disaasa or Injury									1		
68760,	sate t	edical	that initiated events rasulting in death) Last	0.	Due to (o	ras a consec	quance of):							
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State of Maryland / Department of Health and Mental Hygiene

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	items 2	Funeral	1. Merital Stetus	12. Was Decedent	Ever in U.S.	13. Wes Decedent of If Yes, specify Cu		? (Specify Yes or N		- Americ	an Indian,	
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á	al or Attending Ph s efter death. Il Director: After th ed in by the funeral	Certification:	4 ☐ Homicide	building, et	c. (Specify)			City or 1	own, State)			
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	Total		9b. Signature and title of certifier	111	1 1	29c. Lice	nse number		29d. Date signer	Month.	Day, Year)	
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	14	3	O. Name and address of person who	complete design of o	death (Item 23a)	(Type, Print)	0 11	01 11	-11	10-	410	1 11
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aryland show	Ļ	577-42-7419 Usual Rasidance of Dacadant 10a. Stata 10b. County	10c.	City, Town or Lo	cation					d. Inside City Limits
ith with the Maryle 23s or 28s-f show	Director	10e. Street and Number	1	WASHINGI	ON , D.C. 10f. Zip Code			10g. Citizan of V	What Countr	1 1 Yas 2 □ No
ter des	by Funeral	2845 31st pl. N.E 11. Maritel Status 1 Never Merried 2 Marriad 3 Widowed 4 Divorcad	12. Wes Decedent Ever in Armed Forcas? 1 ☐ Yas 2 ☒ No II Yas, Giva Year or Datas:	1	Vas Decedent o	-1603 of Hispenic Orlgin? (Suben, Maxican, Puarl No Specify:	pecify Yes or No-	14. Rec	e - America ck, Whita, at	tc.
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or Health		19a. Informent's Name/Ralationship ARLENE B. HOLLIDA 20a. Mathod of Disposition 15 Burlal 2 Oramation 3 E	NY 20	2845 b. Placa of Dispo	31st. P	PL. N.E., Notece)			. 200	018-1603
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Physician /Medical Examiner	er.	Entar tha diseesa, or conshock, or haart feilura. List only immediata Cause (Final disease or condition rasulting in death)	. Dem	,		tying, such as cardia	c or raspiratory ar	rast,	1 1	Approximata Intervel Batween Onset and Deeth 2 years
The Cords, P.O. Box 68/60, The law requires thet the death certificate be executed at hes been signed by the attending physician and page 2 should be deteched for use as the buriel-transit	/Medical Examiner	Saquentially list conditions, if any, leading to Immadiata cause. Entar Undarfying Causa (Disaasa or Injury that Initiated events rasulting in daath) Lest	. Conge	o (or as a consequence of the co	e he	eart fa	ilure		2	years years
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To the H within 24 To the Fi	Medical	29b. Signatura end title of certifier	niner: On the basis of exem and mennar stated.	Marion and/or inv	29c. Lice	y opinion, death occu		data and place, 29d. Dete signe	d (Month, D	ay, Year)
(5)		30. Nama and addrass of person who Paul Armstron	140011			#102	Laurel	Mo:	2070	7
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3 Time of Death 1 Decedant's Nama (First Middle Last 07:15 AM Month JUNE BURELLO ANTHONY 27 1978 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Nama (If not institution, giva street end number) GEORGES CHEVERLY PRINCE GEORGES PRINCE HOSPITAL CENTER If Undar 1 Yaar | If Under 24 Hrs. (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) 5. Social Sacurity Number Days ★ M 2 F March 8, 1940 Washington, D¢ 579-52-0262 Usual Rasidance of Dacedan 10a. Stata 10c. City, Town or Location 10d. tnside City Limits 1 □ Yas 20 No MD PG Mitchelleville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20716 USA 1415 Fairlakes Court 12. Was Dacedant Ever in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puarto Rican, etc.) Race - Amarican Indien, Black, Whita, atc. 11. Marital Status 1 ☐ Yas ANNo If Yas, Give Yaar or Datas: 1 ☐ Navar Married 🏋 🖾 Marriad 1 ☐ Yas 3(T) No Specify: Specify.Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16h Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 12 Railroad Steam Engineer 18. Mothar's Neme (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Proctor The 1 ma B. Zino Burrello 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code, 19a. informant's Neme/Ralationship (Type, Print) 1415 Fairlakes Court, Mitchelleville, MD 20716 Jacqueline A. Burrello (Wife) 20b. Placa of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, Stata camatary, crematory or other pleca)
Harmony Memorial Park 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 7/2/98 Landover, MD 22. Nama and Addrass of Fecility
William F. Magruder Funeral Home er 2311 MLK Junior Avenue SE Washington, DC 20020 Parti. Entar ha disease, or complications that caused tha death. Do not antar tha mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset end Death immediata Causa (Final disaasa or condition rasulting In daath) . ARTERIOSCIEROTIC CARDIOVASCULAR DISEASE Due to (or es e consequence of): Sequantially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disaasa or injury that initieted evants rasulting in death) Last Dua to (or as a consequence of) Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 □ Yee 2√No 3 □ Probably 4 Unknown 24b. Wera autopsy findings evailable prior to 24e. Wes en eutopsy performed? completion of cause of death? 2 1 No 25. Was casa rafarrad to medical axaminar? 28. Piece of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2□ No 1 Inpatiant 2 ER/Outpatient 3 DOA Manper of Deeth 28d. Dascribe how injury occurred injury at Work?

/Medical **Examiner** ettending physician and for use as the burief-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the

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Physician

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eral Director: After this certmon Physicien: Hospital or Attending death. after

To the Hospital within 24 hours a To the Funeral C edical State

Registrar

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and dua to the cause(s) end manner as stated the course of the time. The time is the time is the time is the time is the time is the time is the time. The time is the time is the time is the time is the time is the time is the time is the time. The time is the time is nination and/or invastigation, in my opinion, daeth occurred et the tima, data and pleca, and due to the cause(s)

29c. Licansa number DIME

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify)

29d. Data signad (Month, Day, Year)

281. Location (Streat and Number or Rural Route Number, City or Town, Stata)

(item 23a) (Type, Print)

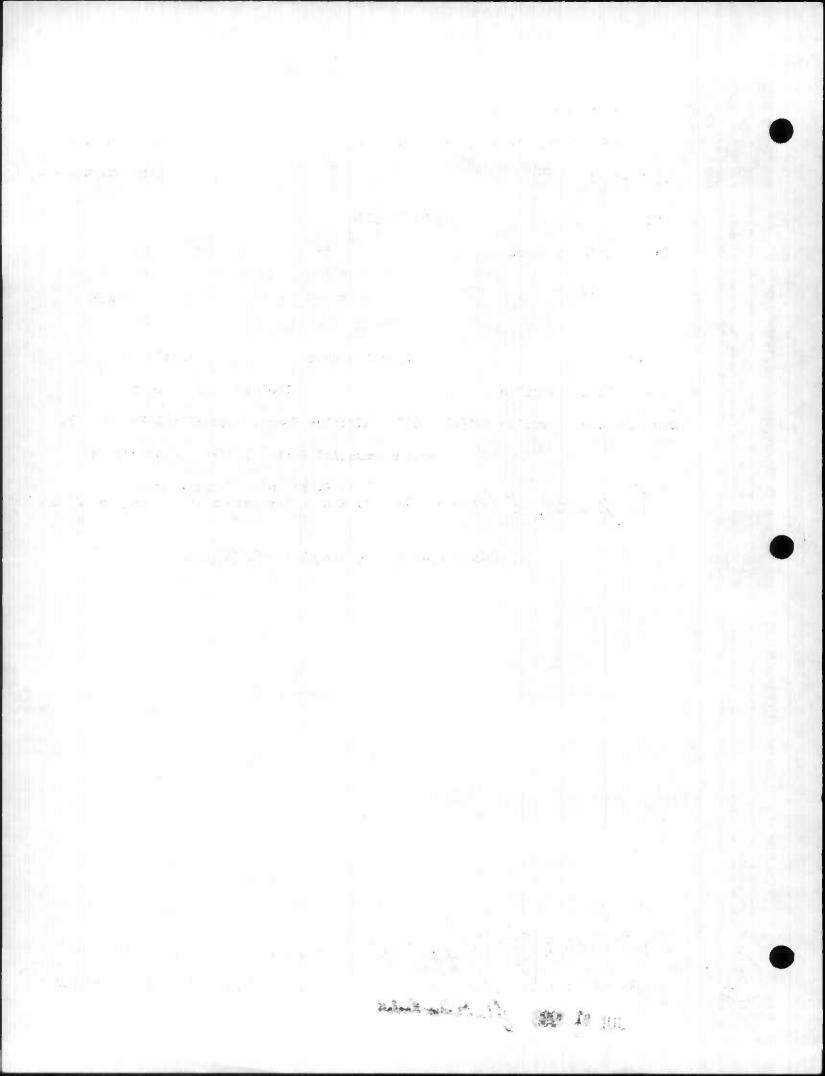
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31. Data filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** JUNE 26, LILLIAN ROSELEAN 1998 8:45 A.M. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE HEALTH SERVICES MONTGOMERY COUNTY If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** 1□ M 21XF Days Yrs. Director 226-34-8222 74 FEB. 18, 1924 VIRGINIA Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits or 28a-f show 1 X Yas 2 No Director WASHINGTON, D.C. 10e. Street and Number 10f. Zip Coda 10o. Citizan of What Country? *natural", or items 23a or edical Examiner must be 20017 1519 OTIS STREET, N.E. UNITED STATES Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarlcan Indian, Black, Whita, atc. 1 □ Navar Married 2 N Married 1 ☐ Yas 2 X No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed The Medical 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grada completed) nd Mental Hyglena. marked other than Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12 MINISTER METHODIST CHURCH 7 is marked other traumatic event. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be Pages 1 and 2 should be nent of Health and Mental CHARLIE MITCHELL SMITH EULAR MAE JONES 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) nt of Health a If Item 27 is or other train 1519 OTIS STREET, N.E., WASHINGTON, D.C. HARRY R. BOWMAN, HUSBAND 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) Data 20c. Location - City or Town, Stata 1 Burlal 2 Cramation 3 Ramoval from State permit. Page Depertment of Important: If any Injury or BRENTWOOD, MARYLAND 4 Donation 5 Othar (Spacify) FORT LINCOLN CEMETERY 7/2/98 21 Signature of Funeral Service Chennel 22. Nama and Addrass of Facilit FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 .00 . Entar tha disease, or complications that ceused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, ck, or heart tailure. List only one cause on each line. Approximata Interval Batw Onsat and Death **Physician** /Medicai Immediata Causa (Final SENILE DEMENTIA disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of): Physician/Medical Examiner PSYCHOSIS - PARANOID DELUSIONS burial-transit Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or Injury that Initiated avants rasulting in death) Last and Dua to (or as a consequance of) RESPIRATORY FAILURE the Dua to (or as a consequence of): usa as DEBILATATED/BEDRIDDEN signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☐ Unknown þ 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 certificata 2X No t ☐ Yas 2 ☐ No director, 25. Was case referred to medical Be 26. Placa of Death (Check only ona) 10 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA After this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. fnjury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding Invastigation after deeth. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be dataminad 3 Suicida in by t 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homleida To the Hospital within 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Cartifian Medicai and mannar stated. 29b. Signatura and titla of certifian 29c. Licansa numbar 29d. Data signad (Month, Qay, Year) 8 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) SUSAN LEGGETT-JOHNSON M.D., 6525 BELCREST ROAD, HYATTSVILLE, MARYLAND 20782 State

Registrar

the Maryland

with

filed within 72 hours after death

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

Hospital

Baltimore, Maryland 21215-0020

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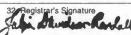
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey Month **Physician** 27, Christine Bryson 10:05 PM June 1998 /Medical 4b. City. Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 ☐ M 2 🔀 F Yrs 217-42-3114 Director 94 June 28, 1903 Washington DC Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at Prince George's Maryland Fairmont Heights Yes 2 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 809 57th Place 20743 IISA permit. Peges 1 and 2 should be filed within 72 hours after deeth 1 Department of Health and Mental Hygiene.
Important: if item 27 Is marked other than "natural", or items 23 any injury or other treumatic event, in Medical Example main Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, Whita, etc. 11 Maritel Status 1 ☐ Yes 2 XNo
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes **XX**No Specify: Black þ 3 ₩ Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Elevator Operator 10th Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) John Andrew Brown Sarah Hunter 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) Erma Mason/Daughter 809 57th Place, Fairmont Heights, Maryland 20743 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 7/6/98 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park Landover, Maryland 22. Name and Address of Facility
J. B. Jenkins Funeral Home 21. Signeture of Funerel Servica Licanses Charles of Downer 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on aech lina. Approximete Interval Between Onset end Deeth **Physician** Cereprovoscular Accidant Immediete Ceuse (Final disease or condition resulting in death) /Medical Examiner Dua to (or as a consaquanca of) Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Diseese or injury that initieted events resulting in daeth) Lest ettending physician end for use es the buriel-tran Dua to (or as e consequance of): Due to (or es e consequence of) Pert If. Other significant conditions contributing to death but not resulting in the underlying causa givan in Pert f. 23b. Did tobacco use contribute to the cause of death? ed by the deteched Respiratory failure signed by the 1 Yes 2 No 3 Probably 4 Onknown þ 24b. Ware autopsy findings aveileble prior to Severe 24e. Wes en eutopsy performed? Completed peen completion of cause of deeth? Hyperteusion certificate has 1 ☐ Yes 2 1NO 1 ☐ Yes 2 ☐ No 25. Was cesa raferrad to medical axaminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 IN Certification: To After this uneral 27. Mennar of Daath 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? 1 PNaturel 5 Pending investigation 1 Yes 2 No n 24 hours efter death.

Ne Funeral Director: A pletely filled in by the fu death. 2 Accident 6 Could not be datermined 3 ☐ Sulcide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a. Cartifiar 1 🖫 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and dua to tha causa(s) and menner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner staled. within 2 To the 29b. Signeture end title of certifier 29d. Dele signed (Month, Day, Year) 29c. License number M.D 6-29-98 hou D48213 30. Nama end addrass of person who completed cause of death (Item 23e) (Type, Print)

W-ASHAI 4000 MITCHEINIPRO #230 Bowie MD 20716

Registrar

31. Dete filed (Month, Day, Yaar)



with the Merylend

3altimore, Maryland 21215-0020

The law requires that the death certificate be executed

or Attending Physician:

Hospital

Division of Vital Records, P.O. Box 68760

JUN 8 8 1988 Carried Williams

State of Maryland / Department of Health and Mental Hygiene 9 8 2 1 7 4

Mariner Health Care of Kensington Montgomery Months Deys Hours Min. Nov. 22, 1926 West Virginia		Certificate of Death	Reg. No.
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25. Wes case referred to medical examiner? 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 27. Menner of Death 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 1 Neture 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 29e. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. (Check only one) 29e. Signature and title of certifier 29e. Defe signed (Month, Dey, Year) 29e. License number 29e. Defe signed (Month, Dey, Year) 29e. Defe signed (Month, Dey, Year) 29e. License number 29e. Defe signed (Month, Dey, Year) 29e. Defe signe	npi		of death?
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The state of the	otor.		Deeth (Check only one)
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30. Name and eddress of person/who completed cause of deeth (item 23e) (Type, Print) ROUGH C GREEN WO 121 MET CAPTILE CH LANSO MD 20774	al C	29e. Certifier 115 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and of	place, and due to the cause(s) and manner as stated.
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	100	Konald C- Green MI 121 Mercaptile	H LEVED MV 20774

		Certificate of Death	, ,	eg. No.	21743
Physicia		1. Decedant's Name (First, Middle, Last) AXCINE BRAGGON	2. Data of Deat	h Day X	3. Time of Death
/Medic Examin		4a. Facility Nama (II not institution, give street and number) PRINCE GEORGES HED CUTE Cheve	cation of Death	4c. County of	_ //
Funeral Director		5. Social Security Number 6. Sex 7. And (In yrs. last birthday) 10 M 27 F 11 Undar 1 Year 11 Undar 24 Hrs. Months Days Hours Min. Usuai Rasidanca of Dacedant	8. Date of Birth (Month, Day, DEC.		Birthplaca (Stata or Foraign Country)
with the Maryland a or 28a-f show Lbe notified at	tor	10a. Stata 10b. County 10c. City, Town or Location MD PRINCE GEORGES (Apital Hats)			10d. Inside City Limits 10d Yas 2□ No
£ 8 3	Funeral Director	10a. Street and Number Nova Ave. 20743	1	og. Citizen of Wh	at Country?
5-0020 72 hours after death natural, or ferms 23 dical Examiner must	by Fune	11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? 1 □ Navar Married 2 Married 1 □ ∀as 2 Marcol 3 □ Widowad 4 □ Divorced 1 □ Yas 2 Marcol 1 □	ecify Yas or No- Rican, atc.)		American indian, White, atc.
21215-0020 d within 72 hours af glene. r than "natural", or tre Medical Exam	Be Completed	15. Decedent's Education (Specify only highast grada complated) Elamentary/Secondery (0-12) College (1-4or 5+) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)	ing	16b. Kind of Busin	nass/Industry Dical
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Mg 2 left a 27 le 27 le 1 frau	ř	19e. Informent's Name/Ratationship (Type, Print), 19b. Mailing Address (Street and Number or Rura ANITA WATSON 5753 FALKLAND			., .
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Balt permit. Departm importa any inje		21. Signature of Funaral Sarvice Usensae 22. Nama and Addrass of Facility STERY 29	FUN	ERAL THA	SERVICE VE WIDE
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8760, ate be executed hysician and the buriel-transit	Examiner	Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Ceusa (Disease or injury) Ceusa (Disease or injury)			10 MONT
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ecords lew requires as been sign	Completed by		24a. Was a perform		24b. Wara autopsy findings available prior to completion of cause of death?
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of Vita Physicien: this certific ral director,	To Be	25. Was case refarred to medical axaminar? 1		e) ince 6 Dothar	(Specify)
Division of Vital Records, To the Hospital or Attanding Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled.	Certification: 1	27. Mannar of Death 1 Netural 5 Pending invastigation 2 Accident invastigation Could not be	28d. Describe ho	w Injury occurred	
Hospital	edical Cer	29a. Certifiar (Check only Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred	and dua to the co	eusa(s) and mann	nar as stated. d dua to tha cause(s)
To the within 2 To the comple	Mec	one) and mannar stated. 29b. Signatura and titia of cartifiar 29c. Licansa number	2	9d. Date signed (Month, Day, Year)
F 3 F 3		8to 11 D39776		6/21/9	<u>P</u>
		30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) DR Steve Yu 3001 Hospital Drive Cheverly 31. Data filed (Month, Day, Year) 32. Registrar's Signature	md.	20785	
Stat Registra	_	31. Data filed (Month, Day, Year) JUN 2 9 1998 32. Registrar's Signature	-		

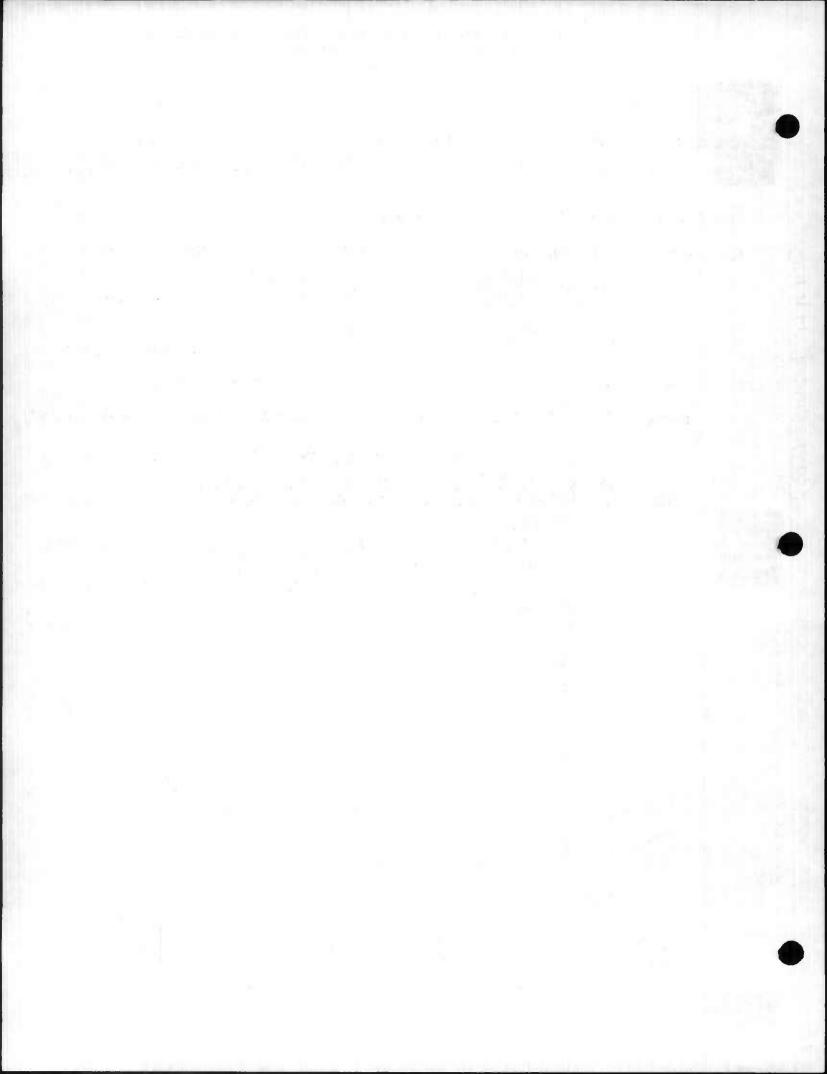
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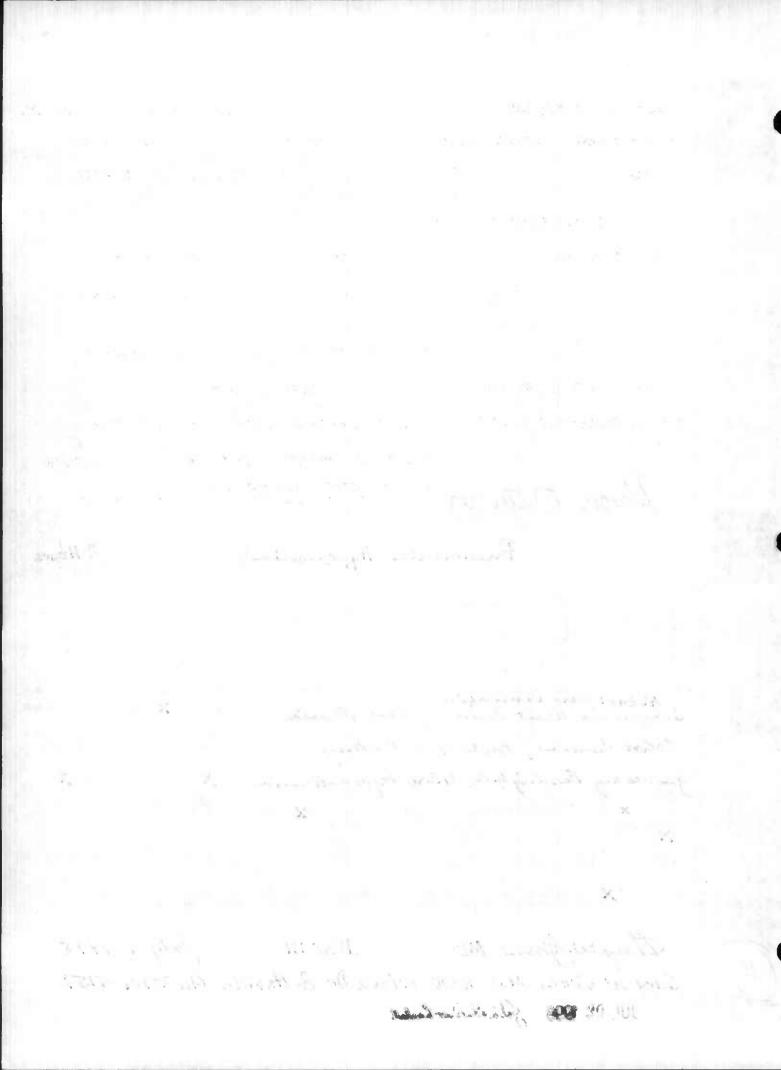
TO SERVICE THE THEORY CANDED STORM THE SERVICE OF SERVICES.

Physician	Ba.Part II Per 1. Decedent's Neme (First, M JOSE			o cr oe	imeate of	Deaur	2. Dete of Dec Month June	Reg. No. Day 26,199	Year 8	3. Time of Death 9:10 PM
/Medical Examiner	4a Facility Name (If not instit					4b. City, Town, o	r Location of Death		of Deeth	у
uneral Pirector	5. Social Security Number 601–46–5086	6. Sex 1 M 2	7. Age (In	yrs. lest birthday 74 Yrs.	If Under 1 Year Months Deys			,1924	9. Birthpl Count Legas	ece (Stete or Foreign (ry) spi,Philipp
f show	Usuel Residence of Deceden 10a. Stete 10b. Con Md. Mont			City, Town or L					10	Od. Inside City Limits
be notified Director	10e. Street and Number 2306 Ross Ro			JIIVEI D	10f. Zip Code 2091	0		10g. Citizen of W		try?
by Funeral	11. Marital Slatus 1 Never Married 2 3 Widowed 4 Divo	12. Was Arm Married 1	Decedent Ever ed Forces? Yes 2 No es, Give			Hispanic Origin? ben, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)	14. Race Bleck	- America k, White, e	
Be Completed		edent's Education ighest grede completed (12)	eted) ege (1-4or 5+)	16a. Dece (Give life.	deni's Usuel Occu e kind of work done DO NOT use retire Barber	pation during most of w ed)	rorking	16b. Kind of Bus		
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any injury or other traumatic en once. To E	19a. Informent's Neme/Relet Ludy Cabanas 20e. Method of Disposition 1 🖁 Burial 2 □ Cremeti 4 □ Donetion 5 □ Othe	/ Daught	er	2306 Db. Pleca of Disp cometary, cre		., Silve	r Spring Dete /7/98	Md., 20 20c. Location - 0	910 City or To	
for use as the burishtransit representations of	23a. Pentr. Enter the disease shock, or heert failure. Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Lesl	e	Sus Due Lecci Due		nquence of): Www.nquenca of):		el uz			Approximete Intervel Between Onset end Deeth
should be detached leted by Physi	Per II. Other significant con Recurs	and as	purp	00	underlying cause g	iven in Pert I.	1 🗆	,/	3 Prot	the csuss of death? bably 4 Unknown bre autopsy findings aliable prior to npletion of cause death?
2 2							10	res PONO	10	Yes 2□ No
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ther this certificaneral director on: To Be	examiner? 1 Yes 2 Ne 27. Menner of Deeth 1 Neurel 5 Pe 2 Accident Inv 3 Suicide 6 Co 4 Homicide 29a. Certifier 1 Territ	Hospital: anding restigation puld not be termined 28e. attying Physician: 1 cal Examiner: On end	Dete of Injury (Month, Dey Yea Plece of Injury - building, etc. (St	28b. Time Injury At home, ferm, socify) knowledge, dee	of 28c. Inju We M 1E treet, factory, office th occurred et the t pvestigetion, in my	iher: 4 Nursing iny et ohk? Yes 2 No	placeth (Check only of placeth) (Check only only only only only only only only	dence 8 Other occurrence of the second secon	er or Rura	I Route Number, ated. the ceuse(s)

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The following of the part of t		Funeral	Г	5. Sociel Security Number 6. S	ex 7. Age (i	In yrs. lest birti			If Under 24 Hrs.				e (Stete or Foreign
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234. Part I. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest. Immediate Cause (Final disease) or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest. Immediate Cause (Final disease) or conditions. Immediate Cause (Final disease) or condi	Balt	permit. Departmin imports eny inju		Dudie! The	struthers	M00583						MARYI	AND 20640
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Due to (or es e consequence of): Cause (Disease or Injury) Due to (or es e consequence of):	,	execut n and ial-trar	Exar	Sequentially list conditions, if any, laading to immediate	Du-	e to (or as a o	onsequence of)):					,,,,,,)
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably This norm of the cause of death?	9	th ce tandi	an		d								
The state of the s		he at	Sici	Part II. Other significant conditions co	entributing to death but n	ot resulting In	tha underlying	cause gi	van in Part I.	23b. Did	tobacco uss co	ntribute to th	e causs of death?
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D-20629 Name and address of posso who complated causa of death (Itam 23a) (Type, Print) 11345 Pembrooke Square, Suite 103 George Wathen, M.D. Waldorf, Maryland 20603	iá	afte Dir	art	4 LI Homicide	bullding, etc. (5	Specify)				City or To	wn, Stete)		
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George Wathen, M.D. Waldorf, Maryland 20603		->-0		- Market	711	VIL	_ n	1-20	620		711	110	XX.
George Wathen, M.D. Waldorf, Maryland 20603			1	No Alamin and address of particular		h /ltem 22a) /7						7	10,
waldoll, flatyland 20005			(ı (nanı ∠3a) (1	. 1	134	5 Pembro	ooke S	quare,	Suite	e 103
		Sta	ite			Signature	W	ald	ori, Mai	ryland	20603		



Pages 1 and 2 should be filed within 72 hosent of Health end Mental hygiene. It: if flem 27 is marked other than "naturery or other traumatic event, its Medical To Be Completed	HENRY J. CIA 4a. Facility Nama (If not institution, MAGNOLIA GARDE 5. Social Sacurity Numbar 231-14-9934 Usual Rasidanca of Decedant 10a. Stata 10b. County MARYLAND PRINC 10e. Straat and Number 6832 TREXLER RO 11. Marital Status 1 Navar Married 2 Married 3 Widowad 4 Divorced (Specify only highas) Elamantery/Secondery (0-12) 8 17. Fether's Nema (First, Middle, L	TTERBAUGH giva straet and number) NS NURSING HO 6. Sax 1 M 2 F T. Aga 1 M 2 F E GEORGE S AD 12. Was Dacedant Every Armed Forcas? 1 M Yas 2 No 11 Yes, Giva Yaar or Datas: s Education 1 grada complatad) Collega (1-4or 5+) ast) CLATTERBAUGH Ip (Type, Print) BAUGH, WIFE	(In yrs. last birthday, 78 Yrs. 10c. City, Town or L LANHAM rar in U,S. 13.) If Undar 1 Yaar Months Days	If Undar 24 Hr. Hours Mir Hours Mir Specify: Deation during most of word)	Month, Day FEB. 1,	Day 1998 4c. County PRINC Year) 1920 Og. Citizan of V UNITED 14. Rac Bia: Specify 16b. Kind of Bi	year Ze GEORG 9. Birthpiaca Country) VIRGIN 10d. I	a (State or Foraign ITA Insida City Limits 1 □ Yas 2 □ No Indian, ITE
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	Kaisa	Dullen	3	401 BLADE	NSBURG R	D., BREN	TWOOD,	MARYLAN	ND 20722
	23e. Part1. Entar the disaasa, or c shock, or heert feilura. List o	complications that causad in nly one cause on each in e	ath. Do not an	tar tha mode of dylr	ng, such as cardia	c or raspiratory arr	ast,	App	oroximata arvai Batween
Physician									sat and Death
/Medical	Immediete Ceusa (Final disaasa or condition	Page	man : a	Hypo;				2	Hause
Examiner	rasulting in death)	a. Di	ua to (or es e consa	quence of):	x ence				" Dur S
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The law requires that the death cerate has been signed by the ettendir page 2 should be detached for use completed by Physician/N.						240 Wos e	n eutoneu	24h Wara a	utopsy findings
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clan: ertific ector Be		/		/*	26. Place of De	eth (Chack only on	θ)		
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ng P ther ther there		28a. Dete of Injury (Month, Day Y	28b. Tima o	f 28c. Injur Wor	y at k?	28d. Dascribe ho	w Injury occurr	red	
bal or Attending Physician: rs after death. al Director: After this certific ed in by the funeral director, Certification: To Be (2 Accident investiga	lion		_	Yas 2 □ No				
or der de de de de de de de de de de de de de	Suicida 6 Couid no datarmin		- At home, farm, str	raat, factory, offica		28f. Location (St. City or Town		er or Rural Rou	uta Number,
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hour hour y fille		Physician: To the best of n	ny knowladge, daeti	h occurred at tha tin	na, data and place	a, and dua to tha ca	use(s) end ma	ınnar as stated.	
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	(Check only 2 Medical Ex	caminar: On the basis of ax end mannar stated	aminetion and/or in	vastigation, in my o	pinlon, daath occi	urred at tha tima, de	ata and place,	and dua to tha	causa(s)
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(0)	20 Name and all	yours m			0111		yung	1, 17	18
10/	30. Name and address of persor w	no completed cause of daat	n (itam 23e) (Type,	Print)	0 11	and A			
	31. Date filed (Month, Day, Yeer)	32 Registrar's	305 Pin	tsea Dr	belts	ville M	4207	05-11	3/



State of Maryland / Department of Health and Mental Hygiene

				Certificate	e of Death		Reg. No.	2	141
Physician /Medical	1. Decedent's Neme (First, Middle, L Philip	U.		Cho		2. Dete of De	24, 199	98 ^{ear}	3. Tima of Deeth 16:05
Examiner	4a Facility Nema (If not Institution, g Doctors Commun		1		4b. City, Town, or Lanhan		th 4c. County Princ		orges
Funeral Director	215-80-2624		In yrs. lest birt	hday) If Under Months	1 Yeer If Under 24 Hrs Deys Hours Min.	8. Dete of Bi (Month, D Feb.	11 1933	9. Birthp Coun KOT	
n the Maryland	Usuel Residence of Decedant 10a. Stete 10b. County Maryland Prince		oc. City, Town					1	0d. Inside City Limit:
h with the	10e. Street and Number 9313 Kimbark Ave	•		10f. Zip	²⁰⁷⁰⁶		10g. Citizen of V		itry?
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f ehow nit, the Medical Exam set must be notified at the Completed by Funeral Director.	11. Meritel Stetus 1 □ Never Married 2 ☑ Merrled 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ev Armed Forces? 1 Yes 22000 If Yes, Give Yeer or Dates:	er in U,S.	13. Was Decedent Yes, special 1 Yes 2	ent of Hispanlc Origin? (S fy Cuban, Mexicen, Puerl Physics Specify:	pecify Yee or No Ricen, etc.)		e - Americ ck, White, "Kore	etc.
led within 72 hor tygiene. her than "natura nt, fr. Wedical Completed	15. Decedent's I (Specify only highest g	rede completed)		Decedent's Usue (Give kind of won life. DO NOT us	Occupation k done during most of wor e ratired)	rking	16b. Kind of B	usiness/Inc	dustry
other than vent, the Manna de Comp	Elementery/Secondery (0-12) 8 17. Fether's Name (First, Middle, Las	College (1-4or 5+)		nding Ma	chine Mechar		Unk.	1	
Se Se Se	Sing Hung	0				on Kyur	e, Meiden Sumen 1 1	16)	
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Physician on physician end ses the buriel-transit Medical Examiner	23a. Pert1. Enter the disease, or conshock, or heart feilure. List onformation of the condition resulting in deeth) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that inhisted avants resulting in deeth) Lest	Advanced Post Hepa	Encepha ue to (or es e o Liver ue to (or es e o atitis	9013 alopathy consequence of): Cirrhos: consequence of):	on/Hale Fune Annapolis F of dying, such es cardia With Coma is With Fail	ed. lanh	am, MD 2	1	Approximate Interval Batween Onset and Deeth 2 Weeks
thet the death celled by the attendification of the control of the	Pert II. Other significant conditions		not resulting In	the underlying ce	ouse given in Pert I.				the cause of deat
> 00	Hepatorenal Sy Pleural Effusi		g Atele	ectasis		24e. Wa	yes 2474No s en eutopsy ormed?	24b. We	era autopsy findings alleble prior to mpletion of cause deeth?
The lay page 2	Sepsis With Po	ssible Meni	ngitis			10	Yes 2 No		☐Yes 2☐No
certific rector	25. Was case raferrad to medical exeminer? 1 Yes 2 No	Hospitel:	•□===		26. Place of Da				
After fune	27. Manner of Death 1 ⊠ Neturel 5 ☐ Pending 2 ☐ Accident Investigation				A 4 Nursing F Bc. Injury at Work? 1 Yes 2 No	-	how injury occur		y)
To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affert completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Plece of Injury building, etc. (- At homa, fe (Specify)	rm, streat, fectory	, office	28f. Location City or To	(Street and Numb own, Stete)	per or Rura	il Routa Number,
Hospi 24 hou Funer letely fill	29a. Cartifiar (Check only one) Check only 2 Medical Example 1	hysician: To the best of r minar: On the basis of an end menner stete	xamination and	, daeth occurred a d/or invastigation,	it the time, date end place In my opinion, daath occu	e, end due to the urred at tha tima	ceusa(s) and ma , data and place,	annar as si and dua to	tated. o tha causa(s)
To the comple	29b. Signature end title of certifier	· Kerrele	nus		License number D31345		29d. Date signe June 24,		
(3)	30. Neme and iddrass of person who Napoleon C. Mar	celo M.D 40	th (Itam 23a) (chellvil	le Rd. B430				Ř.J.
State Registrar	31. Dete filed (Month, Day, Year) JUN 3 0 19	32 Bagistar's	Signetura	rball	11121				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Year **Physician** LUNC 1998 PAULINE L. CURRY /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's If Under 24 Hrs. Deta of Birth (Month, Day, Year) 11/19/36 If Undar 1 Yaer 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Birthpieca (State or Foreign Country) **Funeral** Deys Months 1 ☐ M 2 🖾 F Hours Min. 61 Director 578-48-7459 Wash., D.C Usual Residence of Decedant the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Md. 1X Yes 2 No P.G. Director Fairmount Hqts. 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5713 J St. 20743 Funeral U.S.A.

14. Race - Amarican Indien, death Wes Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Stetus 12. Was Decedant Ever In U,S. Armed Forcaş? Black, Whita, atc. 72 hours after 1 Nevar Married 2 Merried 1 ☐ Yas 2 ☐ No Maryland 21215-0020 1 Yas 2 No Specify: Yas Giva Specify: Black à 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade complated) 16a. Decedant's Usuai Occupation 16b. Kind of Businass/Industry (Giva kind of work dona duning most of working life. DO NOT usa retired) filed within 7 Hygiena. marked other than Elemantery/Secondary (0-12) College (1-4or 5+) Laundry Technician Private Industry 12th traumatic event, permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other treumatic event, phose. 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meidan Sumema) Eddie Randall Elenora Love 19a. Informant's Name/Ralationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Vivian Randall Burroughs 6356 Maxwell Dr. # 3, Camp Springs, Md. 20746
a of Disposition (Nama of 7/1/08 Data 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of cematary, crematory or other place) 7/1/98 Cheltenham Vet's. Cem. 20e. Mathod of Disposition 1 2 Burial 2 □ Crametion 3 □ Ramoval from State Cheltenham . Md. 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Wash., D.C. 21. Signatura of Funaral Sarvice Licenses rate N lann 23a. Part1. Enter the disease, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediete Ceuse (Final COM disease or condition resulting in death) Examiner Examiner VON physicien and the bunal-transit that the deeth certificate be executed Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or es e consequence of) 98 attending Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? o the signed by ti 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown ۵. Records, by law requires 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to Completed peen completion of causa of death? has The 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificata Division of Vital Attending Physician: funerel director, 25. Wes casa rafarred to medical axaminar? Be 26. Placa of Deeth (Check only one) Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas 2 Na 1 ☐ Inpatient 2 ☐ FWOutpatient 3 ☐ DOA this 27, Mannar of Daath 28a. Dete of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After 1 Natural 5 Pending 1 Yas 2 No eftar death. Director: / invastigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicida 6 within 24 hours e To the Funeral D Hospital edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
2 Madical Examiner. On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifia completely (Check only one) \$ 29b. Signature end title of cartifiar 29d. Dete signed (Month, Day, Year). 29c. License number 30. Nema and eddress of person who completed cause of death (Itam 23a) (Type, Print) Javako 31. Dete filed (Month, Day, Year) JUN 3 0 1998 Registrar

The collection of the collecti

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month **Physician** Elizabeth Isabelle Curry 27, 1998 June 8:40 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5734 Eastpines Drive Riverdale Prince George's If Under 1 Year if Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F Months Days Hours Yrs. **Director** 547-42-2650 66 Feb. 17, 1932 Pennsylvania Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. insida City Limits Peges 1 and 2 should be filed within 72 hours efter death with the Maryle nent of Health and Mentel Hygiene.
Intt if item 27 is marked other than "naturel", or items 23a or 28af show ury or other traumatic event, the Medical Examination must be not the 1 ☐ Yes 2 X No Directo Prince George's Maryland Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 20737 Funeral 5734 Eastpines Drive U.S.A. 12. Was Decedant Evar in U,S. Armad Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surnema) Be P Robert Tate Rutledge Anna Louise Fayed 19e. Informant's Name/Retationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5734 Eastpines Drive, Riverdale, Maryland James F. Curry - Husband 20737 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cramation 3 Removal from State St. Mary's Catholic Church Cemetery permit. Pege Depertment of Important: If any Injury or DDCs. 4 ☐ Donation 5 ☐ Other (Specify) Altoona, Pennsylvania 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gasch's Funeral Home Dasd 4739 Baltimore Avenue, Hyattsville, MD 23a. Part1. Enter the disaasa, or complications that causad tha daath. Do not anter the moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) PROBABLE PULMONARY EMBOLISM Examiner Due to (or as a consequence of): Examiner DEEP VEIN THROMBOSIS certificate be executed physician end s the burief-trans Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): 80 esn 0 23b. Did tobacco uea contribute to the ceuee of death? ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown bengis be de Division of Vital Records, þ 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed complation of cause of death? page 2 hes 1 Yes 2 No 1 Yes 2 No certificate Physician: 25. Was cese referred to medical examiner? Be 28. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) P 1 Yes 2 No \$ CL 28e. Date of Injury (Month, Dey Year) 27. Manner of Death funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After Hospital or Attending 5 Pending efter deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours IX contyring Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

Medical Examiner: Control basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) manner stated. edical 29s. Certifie vithin 2 To the 29b. Signatil d tine of o 29c. License number 29d. Date signed (Month, Dey, Yeer) D10300 June 30, 1998

completed cause of death (Item 23a) (Type, Print)

32. Regisfrar's Signature

Giulio Scarzella, M.D., 8630 Fenton Street, #218, Silver Spring, MD

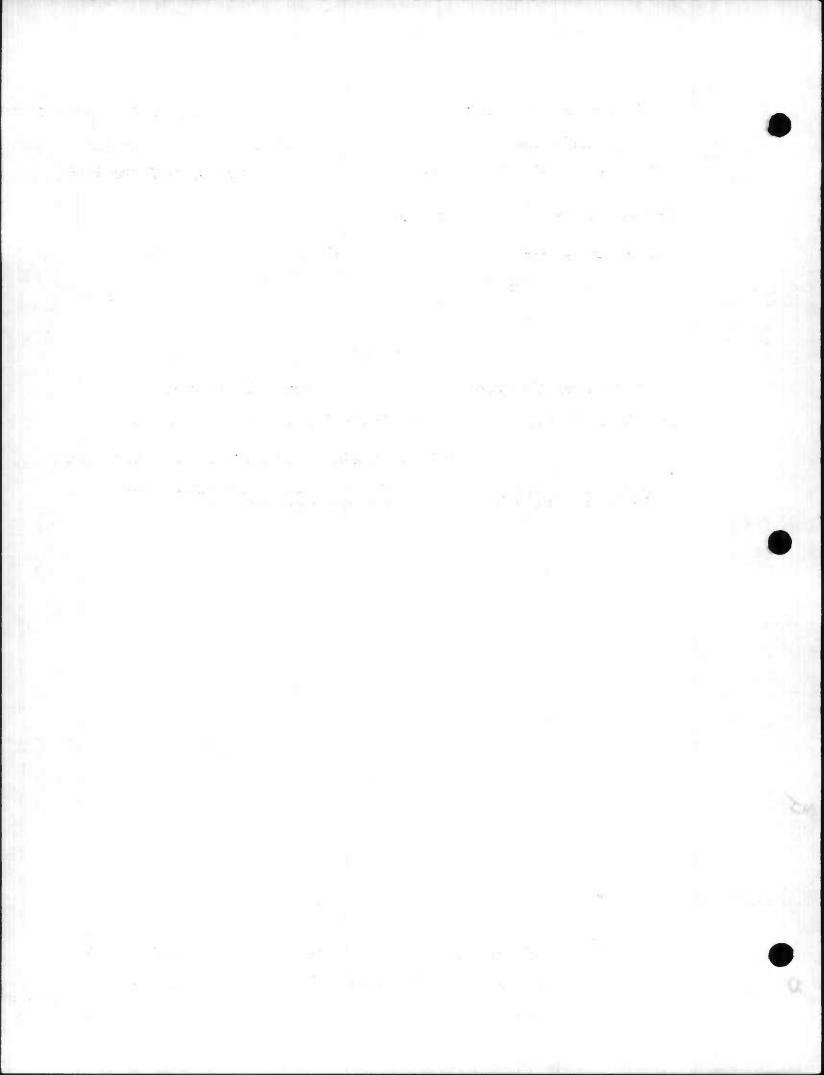
State Registrar

31. Dete filed (Month, Day, Year)

JUN 3 U 1908

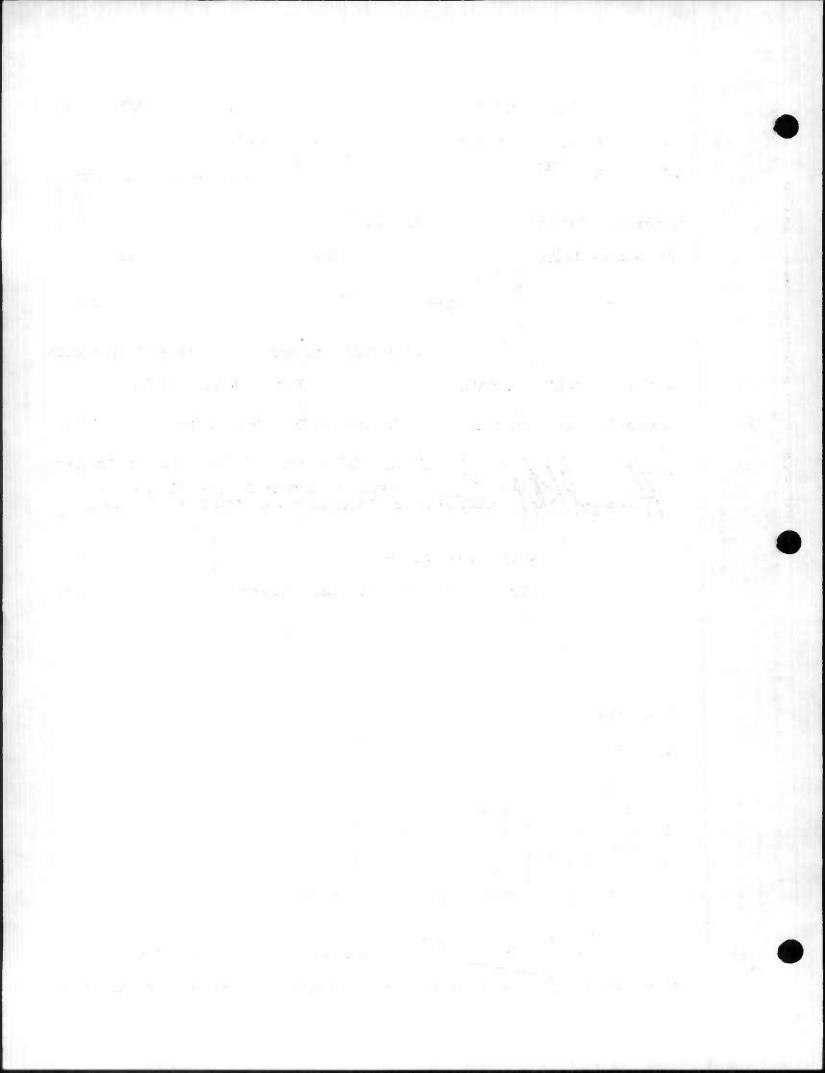


				State of IVI	aiyiai		Certificate			-	Reg. No.	21	750
	Physici	an	1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	ath Day	Year	3. Time of Death
4	/Medi			SON CHENC	WETH	<u> </u>				June 2	5, 199	98	1:40 AM
	Examir	er	4a. Facility Nama (If not institution, g					4	lb. City, Town, o	r Location of Deat	4c. Cour	nty of Death	
			515 Greenridge						Bel A	ir		Harfo	
	Funeral Director		5. Social Security Number 217–20–2537 Usual Residence of Decedent	Sax 1 ☑ M 2 □ F	a (In yrs.		Months I	Year Days	If Undar 24 Hr Hours Mir		th ly, Year) 1926	9. Birtho Coun Mary	placa (Stata or Foreign http) Land
	and **		10a. State 10b. County		10c. Cit	y, Town	or Location					1	0d. fnside City Limits
	r 28a-f show	tor	Maryland Harfor	d	Be	el A	ir						1⊠Yes 2□No
	or 28a	irec	10e. Street and Number				10f. Zlp C	ode			10g. Citizan d	of What Coun	itry?
	2	ai D	515 Greenridge	Road				210	15		USA		
Maryland 21215-0020	or he	by Funeral Director	11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	12. Was Decedant Armed Forces? 1 Na Yas 2 If If Yes, Give Yaar or Datas:			13. Was Deceder If Yes, specify 1 ☐ Yes 22			Specify Yas or No orto Rican, etc.)	Spec	lace - Americ lack, Whita, city: Whi	etc.
5-0	72 ho	Completed	15. Decedent's (Specify only highest of	Education		16a. I	Decedent's Usual (Give kind of work	Occup	ation	orkina	16b. Kind of	Business/Inc	dustry
121	rithin hen	mpie	Elementary/Secondery (0-12)	College (1-4or 5	5+)		life. DO NOT use	retired	1)	orking	Deserve		
D 2	Hygie ther t	S	8 17. Father's Nama (First, Middle, La	net)		Ma	chinist		18 Mother's N	ame (First, Middle	Brewe	-	
lan	d be antal	To Be	Howard Jefferson	· L						ilda Gum		arrier	
ary	should Man	ř	19a. Informant's Name/Relationship			19b.	Mailing Address (Street				vn, State, Zip	Code)
	alth e alth e 27 is pr tre		Lore Chenoweth/W	ife		51	5 Greenr	idg	e Road,	Bel Air	, MD 2	1015	
ore	of He of He f Item		20a. Method of Disposition 1 □ Disposition 3	DRamaval from State	(emetery	Disposition (Name , crematory or other	er plac		Data	20c. Locatio		10000
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State of Maryland / Department of Health and Mental Hygiene ()

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death Dey Year **Physician** Τ., ROLAND 1998 6:30 AM CARTY JUNE /Medical 27 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SAINT JOSEPH MEDICAL CENTER BALTIMORE, MARYLAND TOWSON If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Year) 918 Deys Months Hours ₩ M 2 F Maryland 79 218-07-6427 Yrs. Director Usual Residence of Decedent with the Manyland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ahow the Medical Examiner must be nothed at **X**Yes 2 □ No Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? 305 Custis Street 21001 U.S.A. death Funeral **Neme** Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11 Merital Status 14. Race - American Indian, e filed within 72 hours after dail Hygiene. Bleck, White, etc. 1X Yes 2 No If Yes, Give Yeer or Detes: 1944-46 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2K No Specify: Specify: p White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Civil Service U.S. Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked ofth any Injury or other traumatic event BASS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George E. Carty Ruby B. Singleton 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 461 W. Bel Air Avenue, Aberdeen, Maryland Ronald L. Carty (Son) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from Stete Harford Memorial Gardens 7/1/98 Aberdeen, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funefal Service Licensee 22. Name and Address of Fecility
Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-339.

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each had Aberdeen, Maryland 21001-3399 Approximate Interval Betw Onset and Death **Physician** tmmediate Cause (Finel disease or condition resulting in deeth) /Medical PNEUMONIA Examines Due to (or as e consequence of): Examine the death certificate be executed physician and the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the Due to (or as e consequence of) 980 P.O. Pert II. Other algniftcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yaa 2 No 3 Probably 4 Unknown RENAL FAILURE Records, þ The lew requires should ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed CORONARY ARTERY DISEASE has page 2 1□Yes 2 ANO 1 Yes 2 10 certificate of Vital 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) 1 Yes 20 No Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division To the Hospital or Attending I within 24 hours after deeth. To the Funeral Diractor: After n 24 hours after deeth.
The Funeral Director: After the funeral part of the funeral pa 5 Pending investigation 1 SMatural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. Medical 29e. Certifier completaly (Check only one) 29c. License number 29d. Date signed (Month, Day, Year 29b. Signature and title of certifie cong D24034 30. Name and address of person who completed cause of deeth (item 23a) (Type, Print) LOW, TIMOTHY M.D.

31. Dete filed (Month, Dey, Year) 7620 YORK ROAD, TOWSON MARYLAND 21204 32. Registrar's Signeture

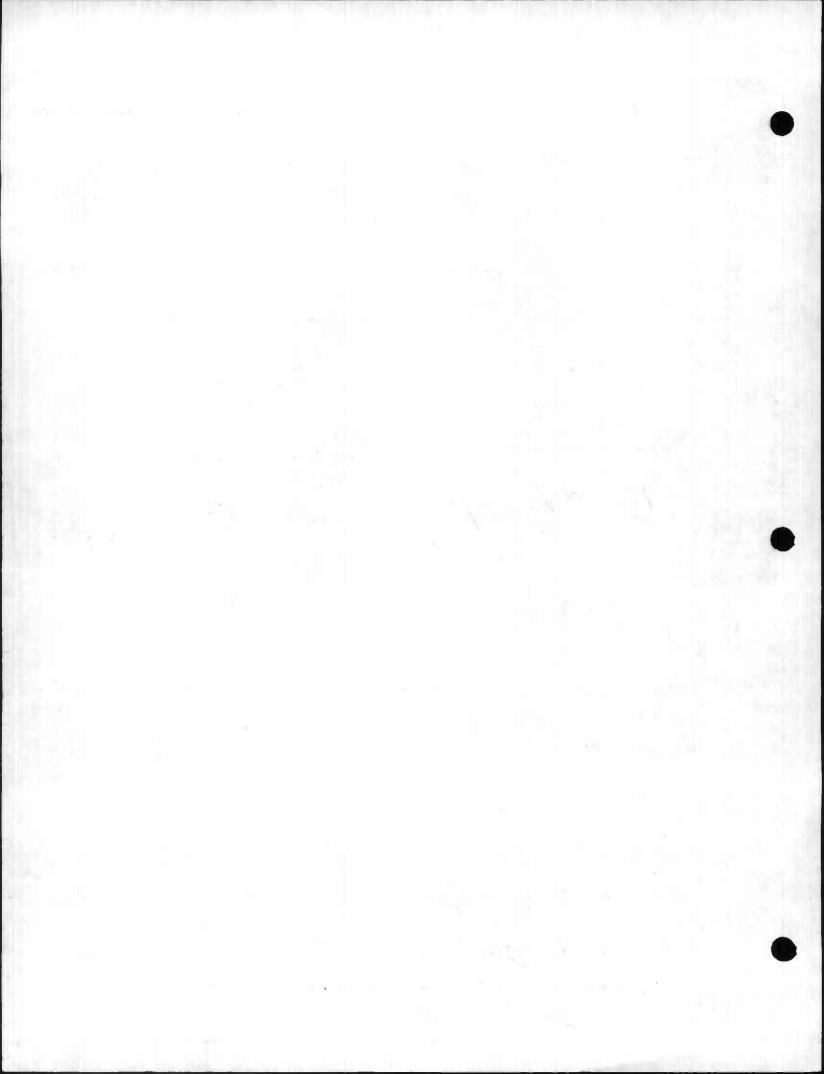
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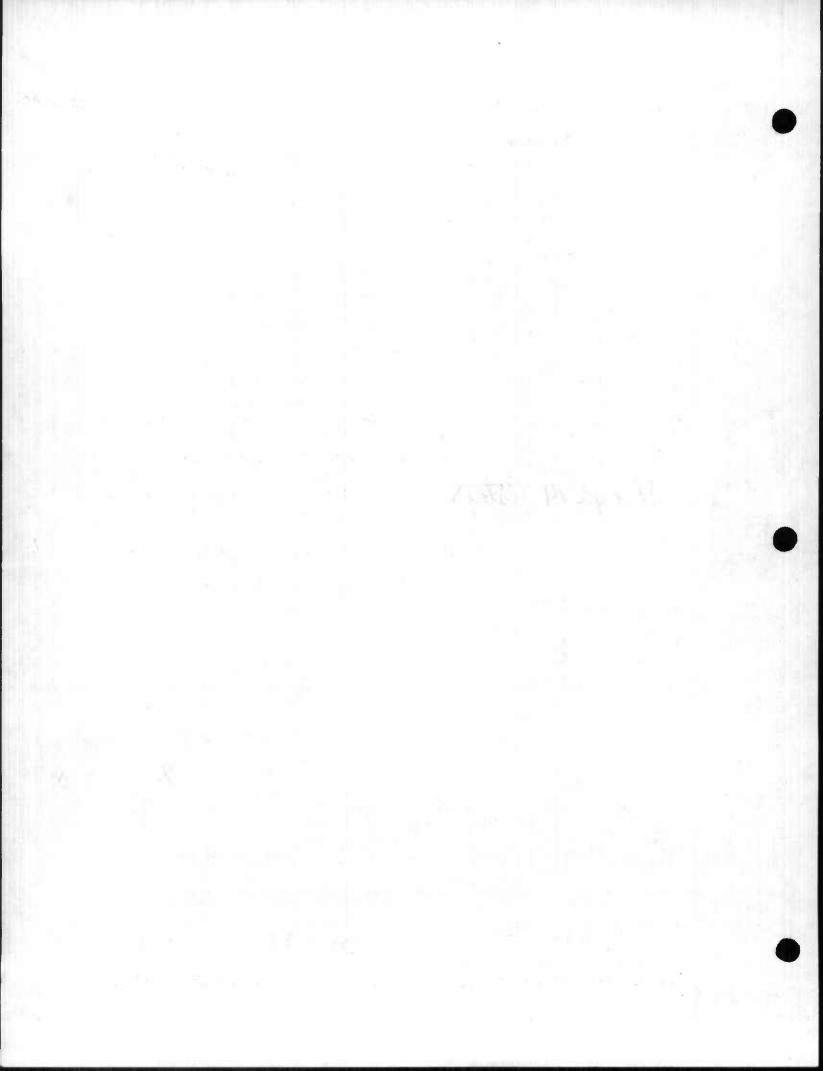
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Howard L. Contee Grace M. Boone	
19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, 2004 Places of Part of P	
Evelyn Contee— Wife 13904 Tower Road Brandywine, Maryland 20	0613
20b. Place of Disposition (Name of cemetery, cramatory or other place) 20c. Localion - City or cemetery, cramatory or other place)	
20a. Mathod of Disposition 20a. Mathod of Disposition 1	Maryland
A Donation 5 Other (Specify) Maryland Veterans July 7, 1998 Cheltenham, 1. Signature of Funeral Service Licensee 22. Nama and Address of Facility	
Adams Funeral Home Aquasco, Maryland	20608
23a. Part1. Enter the dease, or complications that ceused the deeth. Do not anter the mode of dyling, such as cerdiac or respiretory arrast, shock, or heart to ure. List only one cause on each fine.	Approximeta Intarvel Between
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CORONARY DISCASE. Due to (or as a consequence of): if any, leading to immadiate cause. Enter Indepthing.	
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29a. Cartifier 196 Cartifying Physician: To the best of my knowledge death occurred at the time date and class and due to the source of	
Check only (Check only Check only 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta and place, and due to maintenance of the control	s stalad. to tha ceuse(s)
end mennar stated. 29c. Licansa number 29d. Data signed (Mont)	
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D13072 613019	V'
30. Name and address of person who completed cause of daeth (Item 23a) (Type, Print)	
State Registrar JUI 0 6 1998: Julia Sauchen Rendall Name and address of person wind completed cause of daern (term 200) (type, Print) DR.G. Nachnani - 8926 Doodyard Rd, Clintar MD 20735 31. Deta filed (Month, Day, Year) 32. Registrar's Signature JUI 0 6 1998: Julia Sauchen Rendall	>
State St. Deta filed (Month, Day, Year) 32. Registrar's Signature Registrar 1111 0 C 1000: Augustus Registrar's Registrar's Signature	
OHMH 16 Ray 6/95	



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State of Maryland / Department of Health and Mental Hygiene 9 8 2 7 5 4

					Certificate of	Death	R	eg. No.	Sug	1104		
	E	1. Decedent's Name (First, Middle	, Last)	400			2. Date of Deat		Vaar	3. Time of Death		
Physicia:		ROMAINE VIE	GINIA DOD	SON			JUNE 27	Day 1	Year 998	8;00 p.m		
V.	/Medical Examiner	4a Facility Name (If not institution				4b. City, Town, or L		4c. County		0,00 p.m		
	Exa	HOLY CROSS HOS	PITAL			SILVER	SPRING	MONTG	OMERS	7		
Funeral		5. Social Security Number		(In yrs. last birtl	nday) If Under 1 Yee	r If Under 24 Hrs.				lace (Stata or Foraign try)		
vith the Maryland of control of the Control of the	220-16-8043	1□ M 2□XF 7.	2 Y	rs. Months Days	Hours Min.	JUNE 10			NGTON D.C.			
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits			
	MARYLAND MONTGO			MA PARK					X□Yas 2□No			
	10e. Street and Number	TIBRE	IAKO	10f. Zip Coda		1	Og. Citizen of V	Vhat Coun	itry?			
	With Miles	7620 MAPLE AVE	#539		2091	2		USA				
	ns 2	11. Marital Status	12. Was Decedent Ev	rer in U.S.	13. Was Decedent of If Yes, specify Cu		pecify Yes or No-	14. Rac	e - Americ			
21215-0020	urs efter death value all, or items 23s		Armed Forces?		If Yes, specify Cu		o Ricen, etc.)		k, White, o			
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ary	A DE	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Tox								own, Stata, Zip Coda)		
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ē,	f Heel f Heel frem 2 other	20a. Method of Disposition		20b. Place of	Disposition (Nama of , cramatory or other pi	laca)	Date	20c. Location -	City or To	wn, State		
Itimo transion representation function	Pege H: H	1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (St			ND NATIONA		V 7_2	LAUREL,	MADS	ZT AND		
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н	1000	23a. Part1. Enter the disease, or shock, or heart failure. Liat	only ona causa on each line	. Do n	of affiler the mode of dy	ying, such as cerdiac	or respiratory air	est,	1	Interval Between Onset end Deeth		
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Vital Records,	hes by ge 2 st									death?		
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Ta	certificate rector, pag Be Co	25. Was cese referred to medicel				26. Place of Dea	th (Check only or	na)				
	2 00 5	examiner?	Hospital: 1 Inpatient	2 ER/Out	patient 3 DOA	thar: 4 Nursing H	ome 5 Reside	ence 6 Oth	er (Specif	y)		
101	tending Phileath. tor: After thi the funeral cation: 7	27. Manner of Death	28a. Date of Injury (Month, Day	28b. T	ma of 28c. Inj	ury at	28d. Describe h	ow injury occur	red			
Ö	Attending or death. ector: Afte by the fune lifecation	1 ☐Natural 5 ☐ Pending		1007		Yes 2□No						
Division	Afte ecto ecto by the by the	3 Suicide 6 Could r	ned 288. Place of injury	y - At home, far	m, street, factory, office	9	28f. Location (S. City or Town		er or Rura	I Routa Number,		
Ö	to a function of the country of the	4 D Horniolo	building, etc.	(Spacity)			Only or rown	n, Stata)				
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	the Hospi hin 24 hou the Funer mpletely fil	(Check only 2 Madical I	Examiner: On the basis of a and mannar state		or Investigation, in my	opinion, death occur	rred at the time, d	late and place,	and due to	the ceuse(s)		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification	29b. Signeture end title of certifier	100)	29c. Lice	nse number	2	9d. Date signe	d (Month,	Day, Year)		
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	(6)	30. Name and address of person v	vho completed cause of dee	th (Item 23a) (Type Print)	01/)		- 2	-	0		
	6					OIII	177	200: -				
	State	FREDERICK G. B 31. Date filed (Month, Day, Yaar)	ARR MD 5454	s Signature	SIN AVE	CHEVY CHAS	SE, MD	20815				
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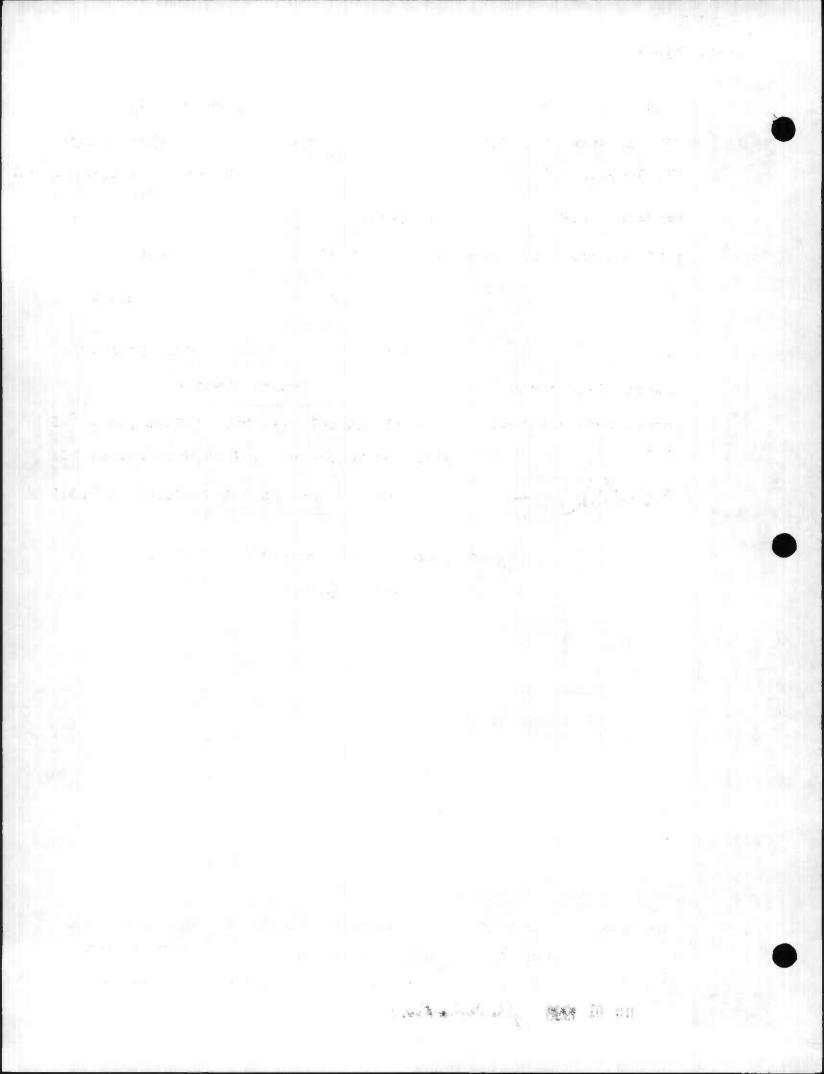
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State of Maryland / Department

artment of Health and Mental I	lygiene	00	0	1	0
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			Ce	rtificate of	Death		Reg. No.	0 2	. 1 / 3 3
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Examiner	4e Facility Neme (If not institution, gir	re street and number)			4b. City, Town, or Lo	cation of Deel	th 4c. County	of Death	
Funeral	,		yrs. last birthday	If Under 1 Year Months Days		8. Dete of Bi (Month, De	rth	9. Birthplac	e (State or Foreign
Director	5 / 8 – 9 4 – 3 3 1 2 Usuel Residence of Decedent		26 Yrs.		10000	9-5-	-71		ngton
anylau	10e. Stete 10b. County	10	c. City, Town or L					10d	Inside City Limit
Se-fine Month	Maryland P,G.		Land						Λ
th with the Ma 23e or 28e-fe at be notified	10e. Street and Number 1127 Capital V	iew Drive	#1413	10f. Zip Code 2 0 7 8					
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 25s-f show or other traumetic event, the Mexical Evan	11. Meritel Stetus **Mover Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes XIXNo If Yes, Give Yeer or Detes:		Wes Decedent of If Yes, specify Cul	Hispenic Origin? (Spe ban, Mexican, Puerto I Specify:	cify Yes or N Rican, etc.)	Blee	e - American ck, White, etc Black	
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permit. Page Department (important: if any injury or once.	21. Signature of Funetal Service Lica	nsee		2. Name end Addr	ress of Facility Sons 563	5 Eads	s St.NF	DC 2	20019
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eath certificate be executed attending physician and for use as the burial-transit clary/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	c	to (or es e conse	equenca of):	Muse				
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	30. Neme and eddress of person who	completed cause of death	(Item 23e) (Type		C.PI.E.		DOINE Z	x, 100	,
	David R	Payler			reet, Balt	imore	Marylar	nd 212	01
State	31. Dete filed (Month, Day, Year)				LCCC, DULL				
Registrar	JIII, 01 199	Jelia deva	Lar Reval	t					



98-3825-033 Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene () ELMER A. DIGGS JR. ITEMS: 23 PART I, 27, 28A-F PER MED FILM G761 7-16-98 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 1998 **Physician** JULY 3, 10:32 AM ELMER /Medical A. DIGGS, JR. 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death **Examiner** MALCOLM GROW MEDICAL CENTER CAMP SPRINGS PRINCE GEORGES If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Deys 12 M 2 ☐ F Vrs **Director** 42 AUGUST 20, 1955 MARYLAND 217-64-8812 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo MARYLAND PRINCE GEORGE'S Temple Hills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3849 28th AVENUE USA 4. Race - American Indian, Funeral 20748 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No ģ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. other than Elementary/Secondary (0-12) Coilege (1-4or 5+) 8th LABORER PRIVATE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 should be ind Mental I 2 ELMER DIGGS, SR. HELEN HAMILTON diam's 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) of Health Bern 27 i HELEN DIGGS / MOTHER 3849 28th AVE. TEMPLE HILLS, MD 20748 Saltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Pages 10 1 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FOREST HILLS CEMETERY 7-10 CLINTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name end Address of Facility MARSHALL'S FUNERAL HOME OF MD any i - 10me 4308 SUITLAND ROAD Helly SUITLAND, MD 20746 Approximate 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Finel disease or condition resulting in death) NARCOTIC AND COCAINE INTOXICATION Examiner Due to (or es a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be exec Box 68760. Physician/Medicai Due to (or as a consequence of): 88 980 10 signed by the a 23b. Did tobacco use contribute to the cause of death? Part if. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, A 24b. Were autopsy findings available prior to completion of ceuse of death? should 24a. Was an autopsy performed? Completed peed The law paga 2 certificate has 1 Nes 2 No 1 Tes 2 No of Vital 25. Was cese referred to medicei exeminer? 26. Piece of Deeth (Check only one) Be Hospitel: 1 ☐ Inpatient 200€R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) OL XX Yes 2□ No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: A 5 Pending investigation Division Attending 1 Natural s after death. UNKNOWN 1 X Yes 2 No FOUND 7-3-98 FOUND 9:10 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rutal Route Number, City or Town, State) 3466 BRINKLEY RD. 28e. Piace of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 Homicide 8 WORKPLACE TEMPLE HILLS, MARYLAND Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier edicai completaly (Check only To the P within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E JULY 4, 1998

Registrar

MARGARITA

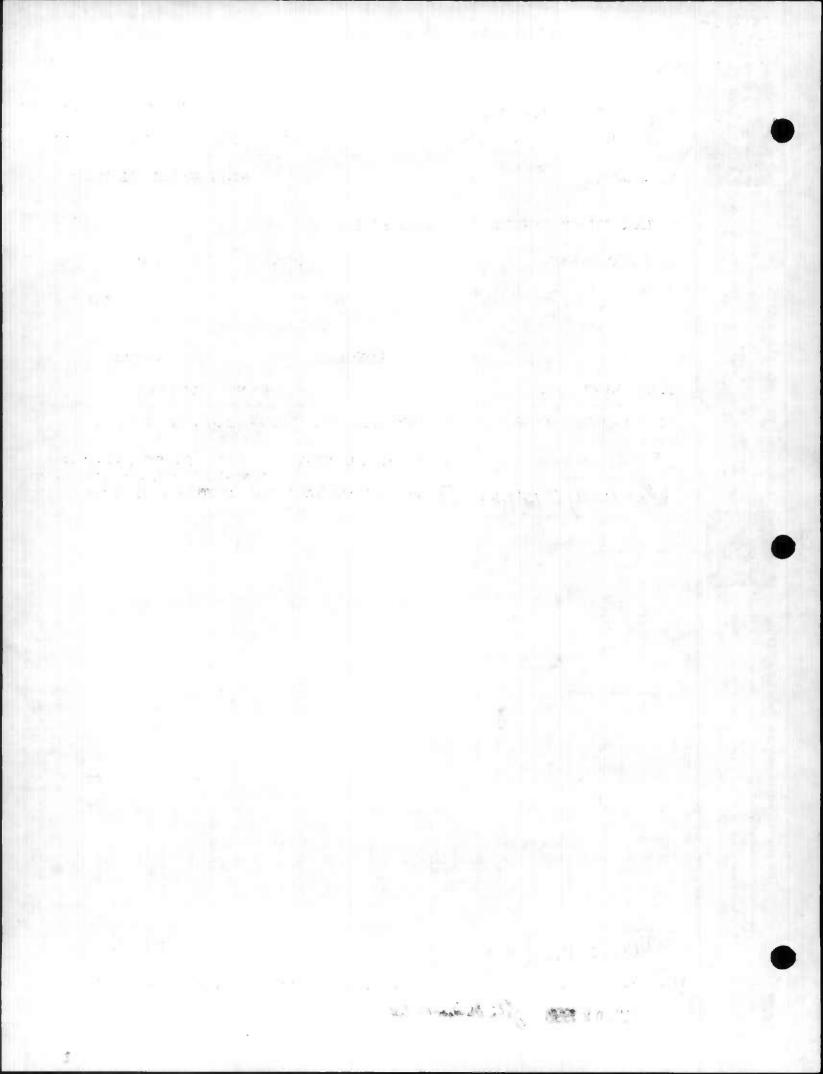
31. Dete filed (Month, Dey, Yeer) Registrar's Signature JUL 0 9 1998

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30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print)

KOREW ND

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Yee **Physician** 1998 neman 6:42 pm JUNE 28 avid /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street end number) 4c. County of Death Examiner TOWSON BALTIMORE GREATER BALTIMORE MEDICAL CENTER 6. Sex 12 M 2 F If Under 24 Hrs. 8. Date of Birth (Month, Dey, If Under 1 Year 9. Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. lest birthdev) **Funeral** Days Months Hours 214-18-3322 DORMAN, DAVAN Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD HARFORD 14 Yas 2□No HAURE DE GRACE Funeral Director 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23e or the Medical Examiner must be 515 Warren U5A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 D No If Yes, Give Yaar or Detas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Stetus Black, White, atc. 1 Navar Married 2 Married 1□ Yes 20 No Specify: Specify: BIACK by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) RUCK DRiver TRUCKING 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be Jennie M. Trimble DORMAN marked Lo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 515 Warren Havre de Graces MD Vorman - WITE FRANCES Item 27 20b. Placa of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State ъ 1 Burlal 2 Cramation 3 Ramoval from State Bakimore, MO Cem 4 Donation 5 Other (Specify 21. Signatura of Funeral Service Lie 22. Name and Address of Facility
BEAKU FUNERAL
552 Lewis St Harre de Carace, MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leilure. List only one cause on each line. Approximate totarval Between Onsat and Death **Physician** Immediate Cause (Final disaese or condition resulting in death) /Medicai 120 **Examiner** Due to (or as a consequence of) Cardio Vaseupy Disease Physician/Medicai Examiner physicien and s the buriel-transit The lew requires that the death certificete be executed Sequentially list conditions, if any, laeding to Immadiate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequenca of): 100 for use as signed by the e Part It. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 2 Unknown 1 Yes 2 No by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Completed is certificate hes director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical Be 26. Plece of Death (Check only one) To Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 RER/Outpatient 3 DOA After this 28e. Dete of tnjury (Month, Dey Year) 27. Manne of Deeth 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury et Work? Certification: 5 Pending Invastigetion n 24 hours after deeth.

Ne Funeral Director: Af pletely filled in by the fu 2 No deeth. 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and manner es steled.
2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifies 29c. License number Chounellus railes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Se Register's Signature 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

JUL 2

State of Maryland / Department of Health and Mental Hygiene

ificate of Death	Reg. No.

2. Data of Deeth

Physician /Medical Examiner

KAY GILLESPIE

1. Decedent's Nama (First, Middle, Last) Frances

3. Time of Death

JUNE 26, 1998

Funeral

Director

the Marylan 7 is marked other than "natural", or items 23a or 28a-f show traumsite event, the Medical Examiner must be notified at death should be filed within 72 hours after and Mental Hygiene. al Hygiene. h and Mental

Baltimore, Maryland 21215-0020 permit, Pages 1 and 2 st Department of Health and Important: If Item 27 is m 6

Physician /Medical **Examiner**

certificate be axecu Box 68760.

P.O.

Division of Vital Records,

physician and s the burial-tran as t use a has this Inneral After 1 death. or Attendation of the order of

hours Funeral Medical within a

Day 1998 Month 26 9:00 AM Kay Gillespie 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death FORESTVILLE PRINCE GEORGES D'ARCY & RITCHIE ROAD 8. Data of Birth (Month, Day, Year) Sept 13 1957 If Under 24 Hrs. If Under 1 Year 9. Birthplece (State or Foreign Country) Maryland 5. Sociel Security Number 7. Age (In yrs. last birthday) Hours Days Min. 1□M 2□F Months 40 577-76-8604 Usual Residence of Decedent 10c. City. Town or Location 10d, Insida City Limits 10b County 1 Vas 2 □ No Director Maryland Prince George's Suitland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 3609 Silver Park Drive #101 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No if Yas, Give Å Yeer or Dates: 14. Race - American Indian, Black, White, atc. 11. Maritel Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 1 □ Never Married 2 □ Married Black 1 Tyes 2 No Specify: Specify: by 3 N Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Cleaner Cleaning Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middla, Last) N.J. Warren Mae Frances Watts 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 3609 Silver Park Dr., #101; Suitland, MD 20746 Donna Wilkinson - Sister 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 D'Burial 2 Cremation 3 DRemoval from State 7/2/98 Harmony Memorial Park Landover, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service License Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Pan Entar the disease, or complications that ceused the ceath. Do not enter the mode of dying, such as cerdiac or respiratory errest, short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) MULTIPLE DISJURIES Dua to (or as a consequence of) Examiner Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated avents resulting in deeth) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? 1 es 2□No 1₽Yes 2□ No 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6XXX ther (Specify) AT SCENE 1 Yas 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 1 Natural 5 Pending DRIVER OF COE, IMPACT WITH DUMP. 1 Yes 2 No investigation FOUND 6-26-48 735AM 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 4 ☐ Homicide RODDWAY D'ARY RD+RITCHE RD. PRINCEGEORGIO Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner as stated.

2X Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) 29d. Date signed (Month, Dey, Year) 29c. Licensa number 29b. Signatura and title of certified

O.C.M.E

A-KOLFW W. 111 Penn Street, Baltimore, Maryland 21201

State Registrar Malihoree

MARGORITA

31. Data tiled (Month, Day, Year)

JUL 02 1

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

32. Registrar's Signatura

Will the season pales of the season

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

JUNE 26, 1998

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Physician	1. Decedent's Name (First, Middle, Last) DERK EVAN GRAHAM									2. Date of Death Month	Day Year		3. Time of Death			
/Medical	4		If not institution, giv		nd num hei)				4b. City, Town,	or Loc	JUNE 25	4c. County		0221AM	
Examiner							יבון זואיבון							PRINCE GEORGES		
uneral		Social Security		ex	7. A		last birthday	If Under			Hrs.	8. Date of Birth (Month, Day,			ace (State or Foreig try)	
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	-	Jsuai Residence o				10-0	7									
ahoy day		Oa. State	10b. County				ly, Town or L							10	od. fnside City Limits 1 Yes 2 No	
r items 23a or 23a-fa sinet must be notified Funeral Director		0e. Street and Nu	mhor	-		WAS	SHINGT	10f. Zip	Code			4/	Og. Citizen of	What Count		
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Examiner Dy Fun			ried 2 Married	1 D	Dacedenied Forcas Yes 2 X es, Give or Datas:	No		 Was Decedant of Hispanic Origin? (Splif Yas, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify: 				tican, atc.)	_	ck, White, e		
yidillo ZIZIO-O vuld be filed within 72 ho Mentel Hygere. riked other than 'natura atic event, the Medical. To Be Completed		/Sno	15. Decedent's Ed	ducation	on 16a. Decedent				el Occup	pation	workin	a 1	16b. Kind of B	usiness/Ind	lustry	
		Eiementary/Second 11			ega (1-4or	5+)	16a. Decedent's Usuel Occi (Give kind of work don life. DO NOT usa retir STUDENT			id)			SCHOOL	L		
		7. Father's Name	(First, Middla, Last))						18. Mother's	Name	(First, Middle, N	faiden Sumen	ne)		
		SAMUEL (GRAHAM				BASILENE FRANKLIN									
reum Emme			Pa. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z.												-40.6	
em 27 other tr			E GRAHAM	/ MO'.	THER	20h I				ER DR.	S.E	. WASHI	NGTON			
Department of Heelth Important: If Nem 27 any Injury or other ti	-	1 ÄBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Spacify) FT. LINCOLN CEMETERY 7-2-98 BRE														
Important: any injury	1	21. Signature of Fi	A LEXANDER S. POPE FUNERAL HOMES 2617 PENN. AVE S.E. WASHINGTON DC 20020												20	
	T	23a. Part1. Entar the sease, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrast, shock, or heart feliure. List only one cause on each line.													Approximate Interval Between Onset and Death	
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miner	1	disease or condition resulting in death) a. ITUITIBLE INJURIES									<u> </u>					
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an end riel-transit Examiner		Sequentially list co	entially list conditions,			Due to (or as a conse	quence of):	:							
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ched ched	F	art II. Other signi	ficant conditions c	ontributin	to death	out not res	sulting in the	underlying o	cause gi	ven in Part I.					the cause of death	
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page 2 should be det												24a. Was an	n autopsy ned?	ava	are autopsy findings aliable prior to appletion of cause death?	
page 2												156Ve	s 2 No	15	Yas 2□ No	
certificate rector, pag		25. Wes case reference	rred to medicei								Deeth	(Check only on	e)			
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unera unera on:		7. Manner of Dea 1 □ Naturai	5 Pending	- ,	Dete of inj (Month, D	y Year)	28b. Time Injury	of	28c. inju		2	8d. Describe ho	winjury occur		ion	
y the f		2 Accident 3 Suicide	Investigation 6 Could not b	9 200	25	98	221	A ^M		Yes 2 No						
Funeral Director: After tetely filled in by the funeraction:		4 Homicide	determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET 28f. Location (Street and Number or R City or Town, Steet) City or Town, Steet) Chenodes							sent Rd	/sterling A			
o the Funeral Director: After this certific ompletely filled in by the funeral director. Medical Certification: To Be (29a. Certifier (Check only one)	1□ Certifying Ph 2類 Medical Exam	niner: On	the basis	of examina	owledge, dea	th occurred	at the ti			nd due to the ca	ause(s) and m	anner as st	aied.	
4 9		one) and manner slated.											9d Data sinns	d /Month	Day Vosel	
To the	1 6	9b. Signature and	Inte of certifier	00				29	C. Licen	sa number		2	ou. Data signi	ed (Month,	Day, rear/	

State Registrar

Dennis 3.
31. Date filed (Month, Day, Year) JUL 01 1998 111 Penn Street, Baltimore, Maryland 21201

cause of deeth (Item 23a) (Type, Print)

O.C.M.E.

JUL BY THE JULY CONCLUS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month WHOT 8. GREEN 1151 1998 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON TAKOWA PARK ADUBNITIST MONTGOMENY HOSPITON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 1 M 2□ F Yrs 05-09-25 248-30-2285 Usual Residence of Dacadant ORANGEBURG, S. 10b. County 10c. Cify, Town or Location 10d. Inside City Limits Montgomery 1 Ves 2 No Takoma Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7600 Mapel Ave. #402 20912 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Specify: BLACK 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. GOVT. Supervisor U.S. GOVT. 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Johnnie Green Maybell Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) , Takoma, MD. 20912 Florence Green - Wife 7600 Mapel Ave. 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 Cremation 3 Removal from Steta
4 Donation 5 Other (Specify) Harmony Mem. Park % Landover Mo M00965
se, or complications that caused **
List of the one ceuse on e--21. Signeture of Ineral Service Dicenses 22. Name end Address of Fecility CUFFEE Funeral Services 6815 Wilburn Dr. CAP. Hgts. MD. blications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final CARDIAC ARRHTHMIA disease or condition resulting in death) Due to (or as a consequance of) Dua to (or as a consequence of): Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? ROWAL FAILURE 1 Yas 2 No 3 Probably 4 Unknown CHRONIC 24b. Ware outopsy findings evalleble prior to completion of cause of death? 24a. Was an autopsy performed? 2 No

Physician /Medical Examiner

physician and s the buriel-trans

been signed by the attending should be datached for use as

director

funeral

filled in by

After

Completed

2

Certification:

Medical

29a. Cartifian

Division of Vital Records.

Attanding Physician:

To the Hospital or Attandir within 24 hours after death. To the Funeral Director: At

Physician

/Medical

Examiner

Director

Funeral

p

10a. State

MD.

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Manyland Inspartment of Hasilth and Mental Hydiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madeal Examinat must be not led any once.

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, laading to immadiata ceusa. Enter Underlying Cause (Disease or injury that initiated evants resulting in daath) Last Physician/Medical

26. Place of Death (Check only one)

25. Was case referred to medicel axapmer?
Yes 2□ No Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Inpatient 2 ER/Outpatiant 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Naturai 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident

6 Could not be 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Sign the and title of certifier 29c. License number

MO 15236 DME

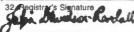
29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

M-0. 30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print)

I. MARGOLIS, M.O. 11125 BOCKVILLE PIKE BLOCKVILLE, MO 20852 31. Data filed (Month, Dey, Year)

State Registrar



A STATE OF THE PARTY OF THE PAR

Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

attanding physician end for use es the burial-transit

signed by the a

certificate has b lirector, pege 2 s

After this funeral

ector: A

after death.

e Funeral Directles of Funeral

within 24 hor To the Fune completaly fi

The law requires that the death certificate be axecuted

or Attending Physician:

Hospital

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

RAYMOND

State of Maryland / Department of Health and Mental Hygien Certificate of Death

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^	2	0	Gra !	0

G/	AFFNEY
	Physician
	/Medical
W	Evaminar

1. Decedent's Name (First, Middle, Last) Raymond Noel Gafney

Howard

2. Date of Deeth Month TUNE

3. Time of Death

4a Fecility Neme (If not Institution, give street end number) 29449 CHARLOTTE HALL ROAD

4b. City, Town, or Location of Deeth

30, 1998 2:00A.M. 4c. County of Death

Funeral

5. Social Security Number ₩ 20 F 390-12-0719

CHARLOTTE HALL

ST.MARYS

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show eny injury or other treumatic event, it a Medical Example must be notified at 128.

Director

Funeral

þ

Completed

Be

Examiner

Physician/Medicai

þ

Completed

Be

2

Certification:

edical

10a. State 10b. County MD

Usuai Residenca of Decedent

10c. City, Town or Location

Yrs

7. Age (In yrs. lest birthday)

77

January 10d. Inside City Limits

USA

10e. Street end Number

Glenwood 10f. Zip Code

1 Yes 2 No 10g. Citizen of Whet Country?

14701 Burntwoods Road

11. Meritel Sieius

Wes Decedeni of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

14. Raca - American Indian, Black, White, etc. Specify: White

1 Never Merried 2 Merried 3 Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S.
Asped Forces?
1 ₹ Yes 2 □ No
1f Yes, Give
Year or Detes:

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

21738

1 ☐ Yes 2 No

16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12)

College (1-4or 5+)

Machinist

22. Name and Address of Facility

Manufacturing

17. Fether's Name (First, Middle, Last) Ray Gafney

18. Mother's Name (First, Middle, Maiden Surneme) Josephine Stimpson Gafney

19a. Intormant's Name/Relationship (Type, Print)
Michael E. Gafney/Son

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 14701 Burntwoods Rd. Glenwood, MD 21738

20a. Method of Disposition
1 ☐ Buriai 2 ☑ Cremation 3 ☐ Removel from Siale

20b. Place of Disposition (Neme of cemetery, cremetory or other plece)

20c. Location - City or Town, State

4 ☐ Donation 5 ☐ Other (Specify)

Metropolitan Crematory7/3/98 Arlington, VA

moosi

AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 LA PLATA, MD 20646.

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respirelory errest, shock, or heart failure. List only one cause on each line.

26. Place of Death (Check only one)

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in deeth)

Atherosclerate Cardiovasculas Disease a Hypertensive

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

Due to (or as e consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Due to (or as a consequence of)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably Unknown

Alzheimers Drease

24e. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No Yes 2 No

25. Was cese referred to medical exeminer? 1 XYes 2 No 27. Menner of Deeit

28a. Date of Injury (Month, Dey Year) 5 Pending investigation

1 Inpatient 2 ER/Outpatient 28b. Time of

28e. Place of Injury - Ai home, farm, sireei, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4XX ursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Naturai

2 Accident

3 Suicide

4 Homicide

1 Cartifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated.

29b. Signature any title of certifier

29c. License number O.C.M.E.

3 DOA

29d. Deie signed (Month, Dey, Year) JULY 1,1998

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who

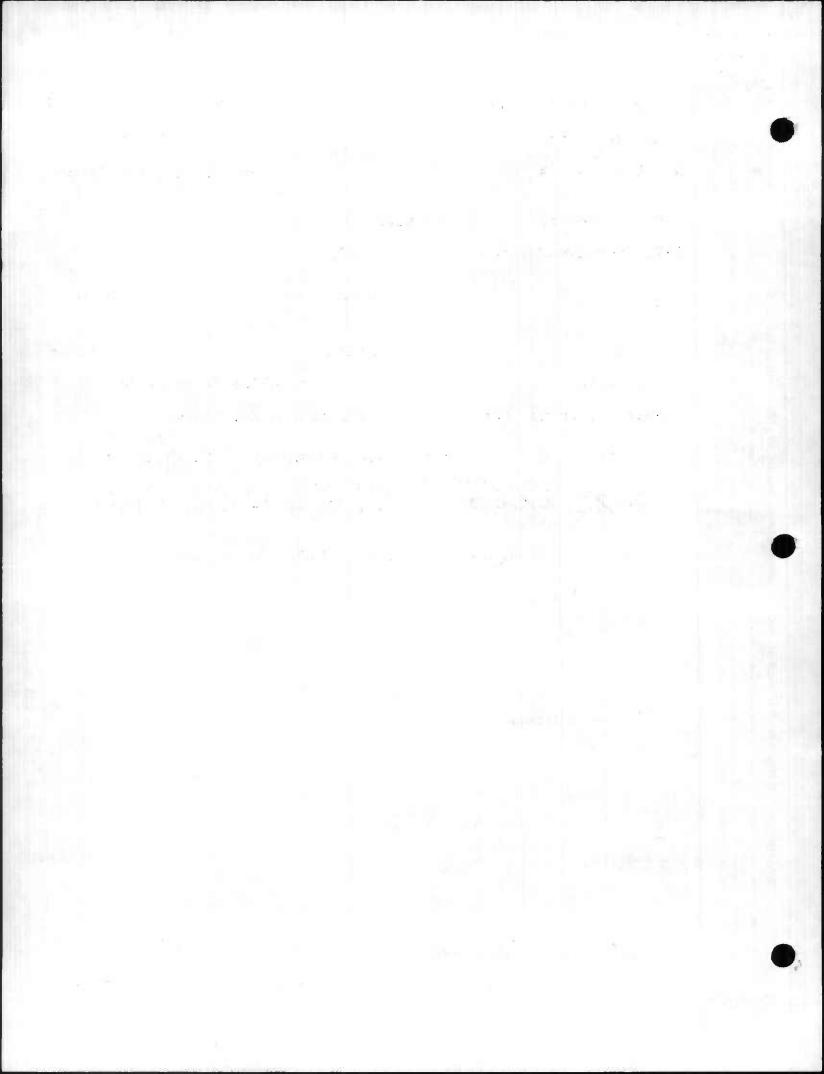
Chute MD J. Dennis 31. Date tiled (Month, Day, Year)

6 Could not be determined

111 Penn Street, Baltimore, Maryland 21201

Registrar

8 Jahr Davelser Revoll 1998 ▶



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

10f Zip Code

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

State of Maryland / Depa

4b. City. Town, or Location of Death

2.0	late of Deeth	3 T	ime of	D
tificate of Death	Reg. No.	6-1/	0	
rtment of Health and Men	tal Hygiene 0 8	217	6	9

Physician
/Medical
Examiner

Barbara Ann Grierson

Dey 1998 JULY 01,

3 Time of Death 1:08 PM.

CA

10d. Inside City Limits 1 Yes 2 No

Funeral

921 TRURO LN. 5. Social Security Number

7. Age (In yrs. last birthday) 1 M 2 F 49 Yrs

10c. City, Town or Location

Waldorf

WALDORF If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. April 16,1949

Charles Birthplaca (Stete or Foreign Country)

4c. County of Death

10g. Citizen of What Country?

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or flems 23s or 28s-f show any highery or other traumatic event, the Modical Examiner must be northed at once. altimore, Maryland 21215-0020

> **Physician** /Medical Examiner

physician and the burial-transit as use a Š Completed page 2 certificate has Be P₀ After this funeral Certification: daath. after death Director:

P.O. Box 68760.

Division of Vital Records,

Physician:

or Attanding

0

24 hours a Hospital

within 2 To the i 4

certificate be

1. Decedent'a Name (First, Middle, Last) 4a Facility Neme (If not institution, give street and number) 578-68-6008 10a. State Directo MD Funeral 11 Marital Status 1 Never Married 2 Married þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Be Frederick Lynch 21. Signature of Funeral Service Licensee Examiner Physician/Medical

Usuat Residence of Decedent 10b. County Charles 10e. Street and Number 921 Truro Lane

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

College (1-4or 5+)

20601 Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

USA Race - American Indian, Bleck, White, etc. Specify: White 16b Kind of Business/Industry

Retailer

20c. Location - City or Town, State

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumame) Doris June Mathias Lynch

19a. Informant's Name/Reletionship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Joseph C. Grierson Jr./Husband 921 Truro Lane Waldorf, MD 20601

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Ptace of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 7/5/98 Alexandria. VA

22. Name and Address of Facility

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.

Arehart-Echols Funeral Home P.A.

fmmediate Cause (Final disease or condition resulting In death)

· CONTACT GUISHOT Due to (or es e consequence of):

MODNO OFHEDD

26. Place of Deeth (Check only one)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest

Due to (or as a consequence of):

Due to (or es e consequence of):

Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

MULTIPLE SCLEROSIS

5 Pendina

6 Could not be determined

24a. Wes an autopsy AND ONLY 1 Yes 2 No 24b. Were eutopsy findings available prior to completion of cause of deeth? 1 Yes 2 No

LIN

Approximete tntervet Between Onset and Death

25. Was case referred to medicat examiner? 1. Yes 2 No 27. Manner of Deeth

1 Netural

2 ☐ Accident 3 ☐ Suicide

4 | Homicide

(Check only one)

29a. Certifier

edical

Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Yeer) FOUND 7-1-98 Investigation

28b. Time of Injury 28c. Injury at Work? 144584

Other: 4 Nursing Home 5XXResidence 6 Other (Specify) 1 Yes 2 No

28d. Describe how Injury occurred SMS JOURS WOT SERF 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

28e. Piece of tnjury - At home, farm, street, factory, office building, etc. (Specify) Rasiberce

921 TAURORD WISLDORF CHAMSO 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E. 29d. Dete signed (Month, Day, Year) JULY 02, 1998

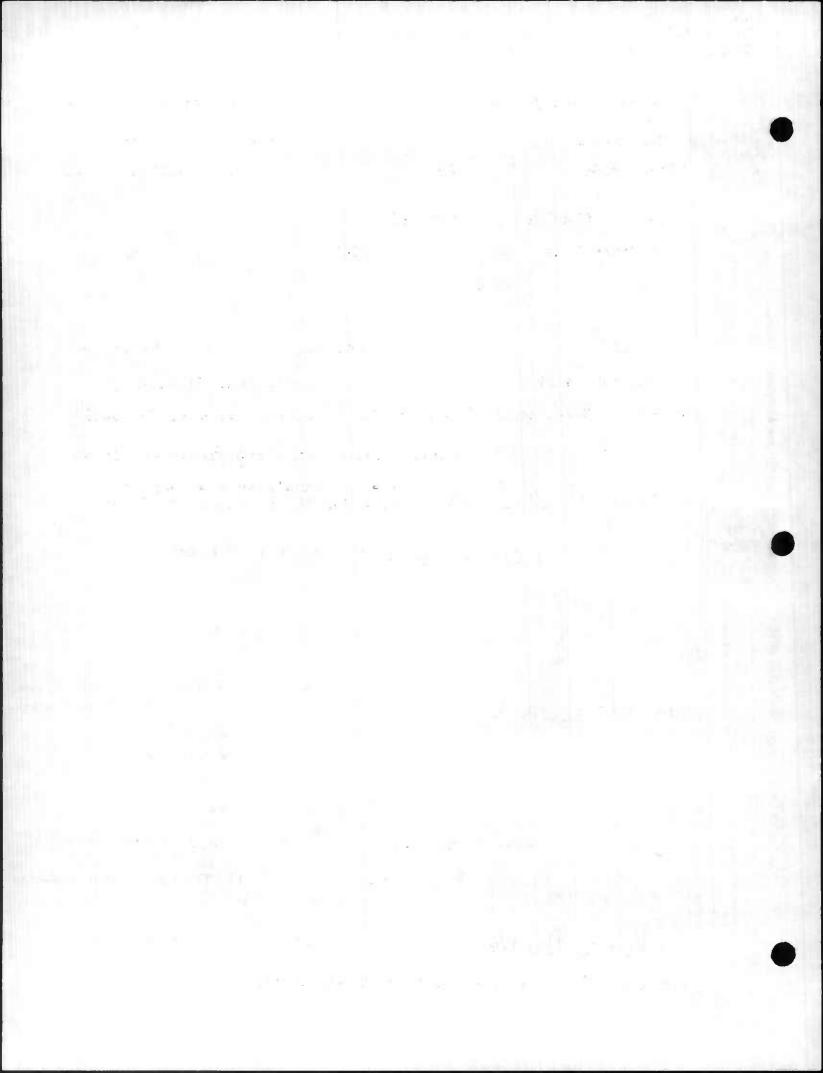
vile 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The

MARGARIOR KORFW MM111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Register's Signature. 31. Date filed (Month, Day, Year) 1998 6 JUL 0



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Lest) 3. Time of Deeth 2. Data of Death Month Robert Francis June 28, 1998 3:54pm 4b. City, Town, or Location of Deeth 4a. Fecility Nema (If not institution, give street end number) 4c. County of Death Prince George's Co. Doctors Community Hospital Lanham If Under 1 Yaar If Undar 24 Hrs. 6. Data of Birth (Month, Day,) Apr. 10 9. Birthplaca (Stata or Foreign Country) Wash., D.C. 5. Sociel Security Numbar 7. Age (In yrs. lest birthday) 1⊠M 2□F Deys 71 Yrs. 578-30-4059 Usual Rasidanca of Deceden 10a Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yas 2 No Maryland Prince George's Lanham 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 4305 Kinmount Road 20706 United States 12. Wes Dacedanf Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Never Married 2 ☐XMarriad 1 ☐ Yas 2 ☑ No Specify: Specify: **Black** 3 Widowad 4 Divorced 16a. Dacedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education 16b. Kind of Business/Industry (Spacify only highast grada complated) Elementery/Secondery (0-12) College (1-4or 5+) Truck Driver Private 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Surnama) Robert C. Henry Clementine Gordon 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Margaret Henry - Spouse 4305 Kinmount Road, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other pleca) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removel from Stata 4 ☐ Donetion 5 ☐ Other (Spacify) Harmony Memorial Park 7/3/98 Landover, MD 21. Signatura of Funarel Sarvice Licansaa 22. Nama and Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Recessor Entar tha disaasa, or complications that caused the death. Do not enter tha moda of dying, such es cardiec or respiretory arrest, or heart fellura. List only ona cause on each lina. Approximate Interval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in deeth) Sequentially list condifions, if any, laading to Immadiata ceuse. Enter Undarlying Causa (Disaase or Injury fhat Initiated avants rasulting in death) Lest Dua to (or as a consequence of). Due to (or es a consaguance of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No PERIPHERAL VASCULAR 3 Probably 4 Unknown 24b. Wara autopsy findings aveilable prior to complation of cause of deeth? 24a. Was an autopsy performed? ANEMIA. 1 🗆 Yas 1 ☐ Yes 2 ☐ No. 25. Was cesa referred to medicel axaminar? 28. Placa of Death (Check only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

λq

Completed

Be

Funeral

Director

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Exampler must be notified at

pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If Item 27 is marked other than any Injury or other traumatic event.

Francis Henr

physicien and the burial-transit Be Completed by To

3 signed t certificata Hospital or Attanding Physician: 24 hours efter deeth. Funeral Director: After this certifical etally filled in by the funeral director, I Certification: To the Hospital or within 24 hours eft To the Funeral DI completaly filled in

The law requires that the death certificate be axecuted

Box 68760.

P.0.

Records,

Division of Vital

Physician/Medical

Registrar

Medical

1 Yas 2 No 27. Manger of Death 5 Panding investigation

6 Could not ba datermined

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28b. Time of

Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 ☐ Yas 2 ☐ No

Certifying Physician: To the best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar es stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

28d. Describe how Injury occurred

29c. License number

29d. Date signad (Month, Day, Yaar)

who completed ceuse of daath (Itam 23a) (Type, Print)

30. Name and eddrass of person with School S 5268 DAWES AVENUE ALEXANDRIA, VA

31. Data filed (Month, Day, Year) State JUL 02 1998

1 Natural

2 Accidant

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

DHMH 16 Rev 6/95

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There are the facility of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth July **Physician** 6:10 Am Homer Albert Hampshire /Medical 4e. Fecitity Nama (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Prince George's Doctor's Community Hospital Lanham 5. Sociei Security Number If Undar 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthpteca (Stata or Foreign Country) Funeral 1 X M 2 □ F Deys Months Hours Min. Yrs. 70 Director 219-18-0868 July 16, 1927 | Pennsylvania Usuel Residence of Deceden 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 ☐ No Director Prince George's Marvland Hyattsville 10a. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? ò 23a Funeral 4107 Farragut Street U.S.A. 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: WWII Was Decadant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 11. Marital Status traumatic event, the Medical Examiner 1 ☐ Naver Married 2 🕅 Married ò 1 ☐ Yes 2 ☒ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highast grede completed) d 2 should be filed within 7 th and Mental Hygiena. 7 Is marked other than "r Elementery/Secondary (0-12) College (1-4or 5+) 12 Department of the Army Auto Mechanic Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Pages 1 end 2 should Harold Glenn Hampshire, Sr. (Unknown) Margaret 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) of Health a Betty Hampshire - Wife 4107 Farragut Street, Hyattsville, Maryland other 20781 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 0 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State permit. Page Depertment of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 7/2/98 Alexandria, Virginia 21. Signature of Funeral Service/Licensee 22. Name end Address of Facility Gasch's Funeral Home 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or healt failure. List only one ceuse on each line. 4739 Baltimore Avenue, Hyattsville, MD 20781 Approximeta Onset and Deeth **Physician** /Medicai Immediete Ceuse (Final SEOSIS 1 work disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner MAELOWA MULTIPLE that the death certificate be executed Sequentielly tist conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Box 68760, physician Physician/Medical Due to (or es e consequenca of): P.O. Part II. Other significent conditions contributing to daeth but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contributs to the cause of death? signed by t 2 No 3 Probably 4 Unknown 1 Yes Records, þ The law requires 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 2000 this certificate 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Certification: 27. Menner of Death 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how tnjury occurred Aftar 5 Pending investigation 1 Neturel death. 1 ☐ Yes 2 ☐ No 2 Accident or Attendiafter death Director: A 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, ferm, streat, fectory, offica building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basts of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end pleca, end due to the ceuse(s) end menner stated.

29c. License number

State

State

Medical Cer

Medical Cer

31. Dete filed (Month, Dey, Year)

JUL 13:1898 Shi da

29b. Signatura and title of certifier

29e. Certifier

32. Registrer's Signature

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

4510 KENILWORTH AVE - RIVERDAGE
Ogistrer's Signature

MD20737

29d. Date signed (Month, Day, Year)

July 2, 1998

Comments the specific states of the states o

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth Month **Physician** 1998 1842 Louise Dean Hoover June /Medical 4a. Facility Nema (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Undar 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, June 9, 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthpiaca (Stata or Foreign **Funeral** Months Days Hours 1□ M 2XF Virginia 217-09-0056 Yrs 86 Director Usual Rasidanca of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at Harford Aberdeen 1 ☐ Yes 200No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 831 Gilbert Road 21001 U.S.A. death Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: þ Specify: White 3X Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry parmit. Pages 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: If Item 27 is merked other than "n any Injury or other traumatic event. Elementary/Secondery (0-12) College (1-4or 5+) 8 Homemaker In home 17. Fethar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meidan Surnama) Be James M. Dean 0 Susie Mae Shinault 19a. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Shirley A. Dotson (Daughter) 300 Calvary Road, Churchville, MD 21028 20b. Place of Disposition (Nama of cemetary, crametory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 6/29/98 Zion Methodist Cemetery Bel Air, Maryland 21. Signature of Fundral Sarvice Licansaa 22. Name and Addrass of Facility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaase or condition rasulting in death) Examiner consequence of): meun Examiner burial-transit Saquantially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disaasa or Injury that initiated avants rasulting in daath) Lest physician the burial Box 68760 Physician/Medical Part II. Other significant conditions contributing to death but not rasylting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? o the 1 Yes 2 0 No 3 Probably 4 Unknown been signed by should be detec م þ Records, 24b. Wara eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed has 1 ☐ Yas 2 ☐ No certificate Division of Vital l or Attending Physician: after death. 25. Wes casa rafarrad to medical exeminar? 26. Placa of Death (Check only ona) 2 NO Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 1 Inpatiant Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Describe how Injury occurred After Natural 5 Panding 1 ☐ Yas 2 ☐ No investigetion 2 Accident Director: 6 Could not be datarmined 3 Suicide 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) Location (Street and Number or Rural Routa Number, City or Town, Steta) in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledga, death occurred et the time, dete and plece, end due to the ceuse(s) end mannar es steted.
2 Medical Examiner: On the bests of examination and/or investigetion, in my opinion, deeth occurred et tha time, deta and place, and due to the ceuse(s) and mannar stated. Medical 29a. Certifian 29b. Signature end title of cartifiar 29c. Licansa number 29d. Dete signed (Month, Day, Year) ul) 30. Nama and address of person who completed cause of death (Itam 23e) (Type, Print)

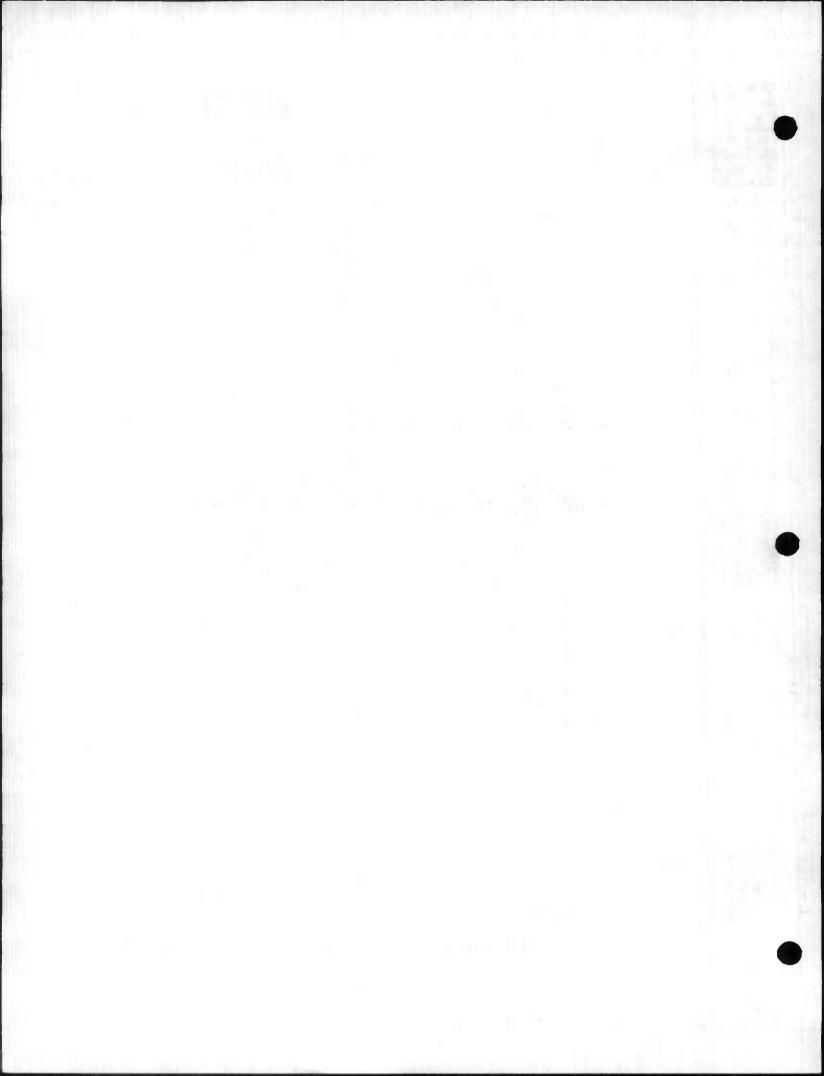
State Registrar

32 Appietrery Signature Raydoll 31. Data filed (Month, Day, Year) JUN2 9 1998

June 25,199

Hoover

Lowse



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth **Physician** WARGARET /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Haure de Grace Nursing Hom Sex 7. Age (In yrs. last birthday) Home Houre a st birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. TIZEN: 5. Sociei Security Number Birthplece (State or Foreign Country) **Funeral** Deys 220-18-6300 Yrs **Director** Usuel Residence of Decedent the Merylend 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Madical Examiner must be notified at HAURE DE GRACE Yes 2 No Director 10e. Street end Number 10g. Citizen of Whet Country? 15H Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No tf Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 þ 3 Widowed 4 □ Divorced BIAC Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. pernit. Pages 1 end 2 should be filed within Department of Health end Mentel Hygiene. Important: If Nem 27 Is marked other than eny Injury or other treumatic event. Elementery/Secondary (0-12) College (1-4or 5+) House KeepER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be SAMUE! Webster NNIE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) H. GREEN Haunede ORRaine Grace 1 Hunter 20c. Location City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 DCremetion 3 ☐ Removal from State 20b. Pleca of Disposition (Neme of cemetery, cremetery or other plece) Dete 6-30 5 ☐ Other (Specify) 4 Donetion Greenmount 22. Name and Address of Facility BEARD Fundral Home 21. Signeture of Funerel Service Lig 54 406,MD 21078 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in deeth) Examiner attending physician and for use es the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Onknown þ 24b. Were eutopsy findings aveilebte prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed page 2 To the Hospital or Attanding Physicien: The within 24 hours after death. To the Funeral Director: After this certificate I 2000 1 Yes 2 No Division of Vital 25. Was case reterred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2010 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28c. Injury et Work? 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 29e. Certifier Medical

State Registrar

pletely

(Check only one)

29b. Signeture end title of cartified

31. Dete fited (Month, Dey, Year)

30. Neme end address of person who of

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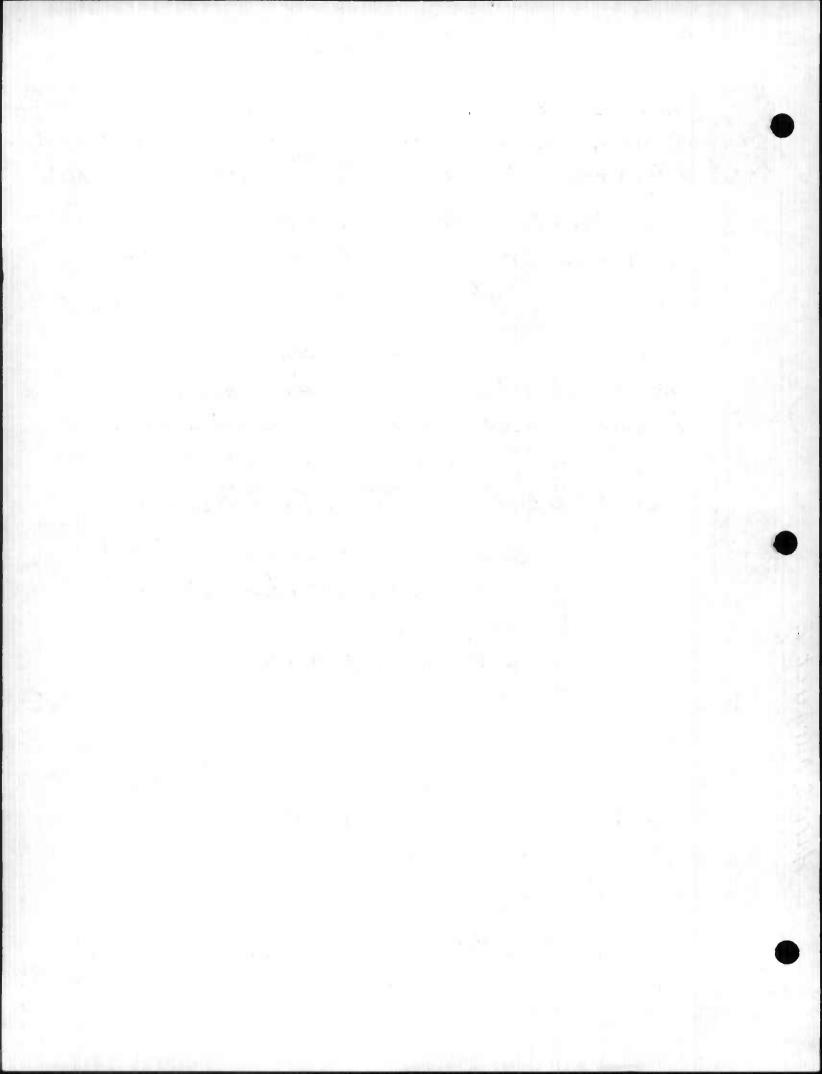
DHMH 16 Ray 6/95

1

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) end manner es stated.

29d. Datg-Bigney (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 21766

						Cert	ificate of	Death		B	leg. No.	0	1 7	00
	TO LOUIS	A	1. Decedent's Name (First, Middle, Last)							2. Dete of Dee	th		3. Time	of Death
	Physici		Norma White Hosk	ins						June	2 ^{Dey} 19	Yeer 98	2:5	5pm
	/Medic Examir		4e. Facility Name (If not Institution, give s					4b. City, To	wn, or Lo	cation of Deeth	4c. County			op
			2903 Krangl Drive					Chur	chvil	اما	Harfo	rd		
_	Funeral	г	5. Social Security Number 8. Sex		(In yrs. lest	birthday)	If Under 1 Yeer	if Under	24 Hrs.			9. Birtho	lece (Stat	te or Foreign
	Director		212-30-5682	M 27 F	67	Yrs.	Months Deys	Hours	Min.	8. Date of Birth (Month, Dey 06/08/	1931	MBoun	try)	
	/land		10a. State 10b. County		10c. City, To	own or Loca	ation					1	0d. Inside	City Limits
	h the Maryland r 28a-f show	ţō	MD Harford	·	Chur	chvill	0						1 X) Yo	es 2 No
	28a	Director	10e. Street and Number		-11.41	0	10f. Zip Code			1	Og. Citizen of V	Whet Coun	trv?	
	3a o		2903 Krangl Drive				21028				USA			
	death with the Maryland orne 23e or 28e-f show it must be notified at	lera		2. Was Decedent E	ver in U.S.	13. W		Hispanic Ori	ain? (Spe	cify Yes or No-		e - Americ	an Indian.	
720	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Instruct, or items 23a or any injury or other treumstic event, the Medical Examiner must be some.	by Funeral	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	lo		es Decedent of I Yes, specify Cub			Rican, etc.)		ck, White,		
212-00	ture it		15. Decedent's Educ		10	6a. Decede	nt's Usuel Occu	pation			16b. Kind of Bu			
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yland	ked be	ToB	John Henry White					Mary	Gra	ce Coll	ier			
3	shound M	-	John Henry White Wary Grace Collier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,											
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	Physician		23a Part1. Enter the disease, or complic shock, or heart feilure. List only on	eations that caused e ceuse on each line	the death. D	123 To not enter	S. Was	hingt Ing, such es	on S cardiac o	t. Havi	re de C est,	race	Approxim Intervel B Onset an	nate Between
7	/Medical		Immediate Cause (Final diseese or condition	100	NG	0	AN CI	SR				1	12 Y	month
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ń	signe be c	by	PARTITION / 10	120141	125		07 4							
, and	v require been si should	e e								24a. Was a perform	n autopsy med?	ava	ailable prio	sy findings or to
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-	Physic this or ral dire	9	1 ☐ Yes 2 No	ospital: 1 🗆 Inpatien	t 2 ER/	Outpetient	3□ DOA Oti	her: 4 Nu	rsing Hon	ne 5 Theside	ence 8 Oth	er (Specify	1)	
=	After th funera	:uo	27. Manner of Deeth 1 Matural 5 ☐ Panding	28e. Data of Injury (Month, Day	Year) 28t	o. Time of Injury	28c. Inju Wo	ry at	2	8d. Describe ho	ow injury occurr	red		
2	Attending or death. ector: After by the fune	Sat	2 ☐ Accident investigation					Yes 2 3	No	-				
2	s after d	Certification:	3 Sulcide 4 Homicide 8 Could not be determined 28a. Plece of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28b. Location (Street and Number or Rundling) 28c. City or Town, Stete)								er or Rura	Route Nu	umber,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f	edicai (29e. Certifler (Check only one) 17 Certifying Physic 2 Medicat Examin	cfan: To the best of er: On tha basis of end menner stat	examination	lge, death o and/or inve	occurred et the ti stigation, in my o	me, date en opinion, daa	d piace, e th occurre	nd due to tha cod at the time, d	ause(s) and ma ete and piace, i	nner as st and due to	ated. the cause	B(S)
	withii To th	M	29b. Signeture and title of cartifier				29c. Licens				9d. Dete signe			
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3			30. Neme and address of person who cor	npleted cause of de	eth (item 23	المات	TIR 1	20	MC	210	47 0	CALL	STO	V

Registrar

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State of Maryland /

Department of Health and	Mental Hygiene	-
Cartificate of Double		-

1768

3. Time of Death

Year

V			Certificate	OI Death	Rei	g. No.
sician edical	Decedent's Name (First, Middle, Last) Anthony	Orlando	Johnson		2. Data of Death Month JUNE	Day 26
	4a Facility Name (If not institution, give str	4b. City, Town, or	Location of Daath	4c. C		

Funeral

Phy

/M

Exa

Director

r than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at

filed within 72 Hygiera. out be mark to 7 is mark Pages 1 and 2 should be rithers of Health a relant: If Item 27 Is njury or other tra Physician /Medical Examiner

Baltimore, Maryland 21215-0020

certificata be executed physician and s the burial-trans Box 68760 attending ed by the al P.O. signed by t Records, peed has certificate Division of Vital director, this funeral or Attending Pattar death.

Director: After

1998 7:47P.M. ounty of Death 5714 EARLY STREET CAPITAL HEIGHTS PRINCE GEORGES If Under 1 Year if Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) 1977 9. Birthplace (State or Foreign Country) Months 1 X M 2 □ F 20 579-96-8967 September 10, Washington, D.C. Usual Residence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYas 2 No Directo District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2314 Minnesota Avenue, S. E. 20020 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Giva 1 ☐ Yes 2 X No Specify: Specify: Black à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th grade Unemployed None 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) a Ewell Bolden Samuel 1 Wesley Mary 2 Lou 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Edward Johnson (brother) 4318 Dubois Place, S.E.; Washington, D.C. 20019 20b. Placa of Disposition (Nama of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata **Burial 2 Cremation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery/July 3,1998 Suitland, Maryland 21. Signeture of Emeral Service Lipensee 22. Name and Address of Facility Robert G. Mason Funeral Home, Inc. 1661 Good Hope Road, S.E.; Washington, D.C. 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events rasulting in death) Last Due to (or as a consequenca of) Physician/Medical Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown p 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy 1 Yes 2□ No 1 Yes 2□ No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6XX6ther (Specify) SCENE 2 1X Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation 1 Neturel UNK Yes 2 No Est 8 UNK M 2 Accident June 26 1998 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide unk Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as atated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and O.C.M.E. JUNE 27, 1998

State Registrar 31. Dete filed (Mo

32. Registrer's Signeture

cause of death (Item 23e) (Type, Print)

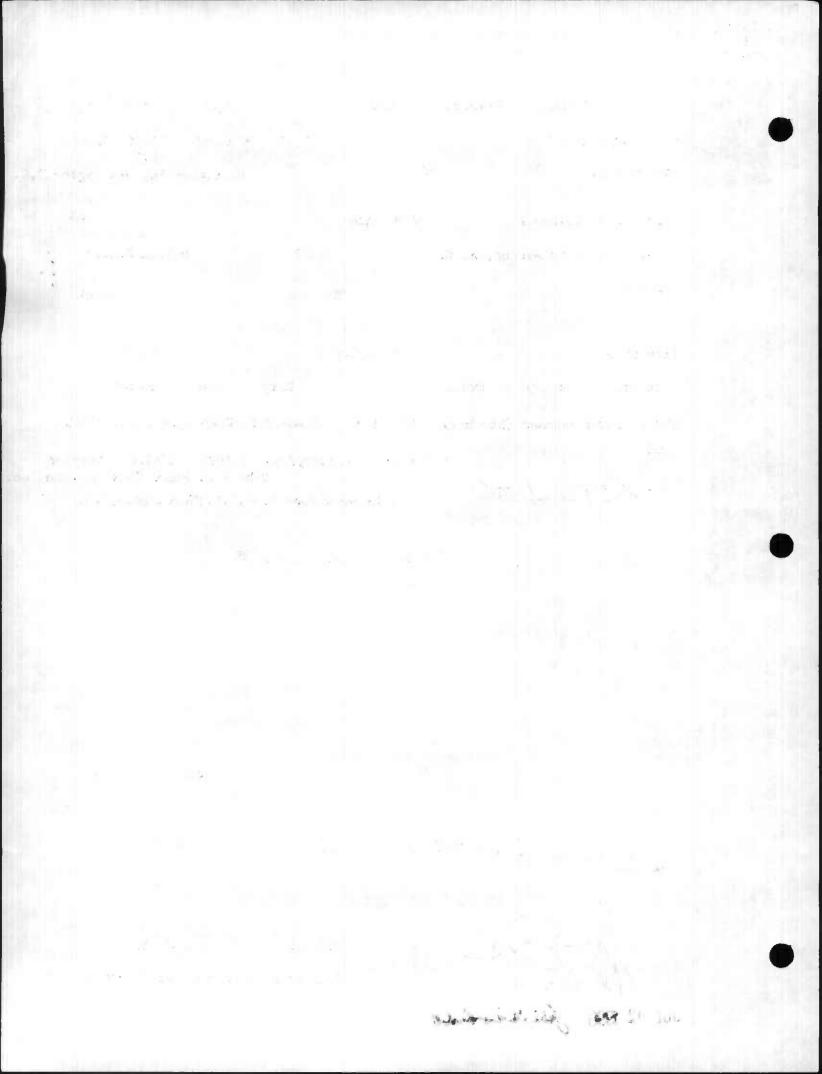
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30. Name and a

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		State of Ma	•	ertificate of			Reg. No.) (1/09	
Dharatatan	1. Decedent's Name (First, Middle, Last)								3. Time of Death	
Physician /Medical	Harry A.	Keedy				June		998	10:40 P.M	
Examiner	4a Facility Name (If not Institution, give				4b. City, Town, or Greenbe				Tooman ! a	
	Greenbelt Nursing Home Greenbelt Scholar Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year If Under								George's	
Funeral Director	216 05 0572 XX M 2□F 94 Yrs. Months Days Hours Usuel Residence of Decedent					Oct. 8	th Year) 1903	Mary	olece (Stete or Foreign of Land	
and wa	10a. State 10b. County		10c. City, Town or	Location				1	0d. Insida City Limits	
Many 1 sho	Maryland Carroll		Manche	ster			1 🗆 Ya		1 ☐ Yas 2€No	
3a or 28a-f si the roof of	10e. Street and Number 3590 Water Tag Road				10f. Zlp Code 21102			10g. Citizen of What Country? United States		
hours elter death with the Maryland tural; or items 23s or 28s-f show el Examiner must be notified at ed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married \$\text{\tilleft}\text{\text{\text{\text{\text{\text{\text{\text{\text{\te}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\te}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tett}\text{\texicleftentet{\text{\texitet{\texicleftet{\text{\texicleftente\text{\texit{\texi{\text{\texicleftet{\text{\text{\texi}\t	12. Was Decedent Ev Armed Forcas? 1 Yes 2 No If Yes, Give Year or Dates:		3. Was Decedant of If Yas, specify Cul		Specify Yes or No to Rican, atc.)		e - Americ ck, White, c: Wh:		
ed within 72 hours of ygiene. Set than "natural", c. ft, the find cell and Completed by	15. Decedent's Edu (Specify only highest grade		16a. De	cedent's Usual Occu	ipation	rkina	16b. Kind of B	usiness/In	dustry	
within with the series of the	Elementery/Secondary (0-12)	College (1-4or 5+	-)	ive kind of work done DO NOT use retire		, Kung				
	12		Cel	anese Pla	_	ma (Finat Adiatella	Manufa		ing	
marked off marked off umatic ever	17. Father's Nama (First, Middle, Last) Charles N. Keedy					me (First, Middle larnick	, Meideri Sumen	10)		
Ith and Ith an	19a. Informant's Name/Reletionship (Ty Faye Shockro Dau	rpe, Print) ughter		alling Address <i>(Stree</i> 90 Water						
permit. Peges I ar Department of Hea Important: If item 2 eny Injury or other pnce.	20a. Mathod of Disposition 1 Burial 2 Cramation 3 F 4 Donetion 5 Other (Specify)			sposition (Name of cremetory or other plants rg Memori	-	, 1998	20c. Location -		own, Stata Maryland	
Physician /Medical Examiner	23a. Part1. Enter the disease, or complishock, or heert feilure. List only or Immediate Cause (Final disease or condition resulting in death)	a. A Collins	oue to (or es a con	sequence of):	ing, such as cardio	o or respiratory a		1	Approximate Interval Between Onsat and Death	
death certificate be assecuted e ettending physician and ed for use as the buriel-transit siclan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C	due to (or as a con							
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hys his al di	1 Yes 21.00 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Spe								(y)	
tel or Attending P rs efter death. al Director: Attert led in by the funera Certification:	3 Sulcide 6 Could not be 4 Homlcide determined	28e. Place of Injur building, etc.		street, factory, office	a	28f. Location City or To	(Street end Numi wn, State)	ber or Run	al Route Number,	
To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the Medical Certific	29a. Curtiful Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated. Madicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To the comple	29b. Signature and title of goriffier			29c. Lice	nse number		29d. Date signe	d (Month,	Day, Year)	

State Registrar

31. Date filed (Month, Day, Year)

JUL 02 1998

32 Registrar's Signature

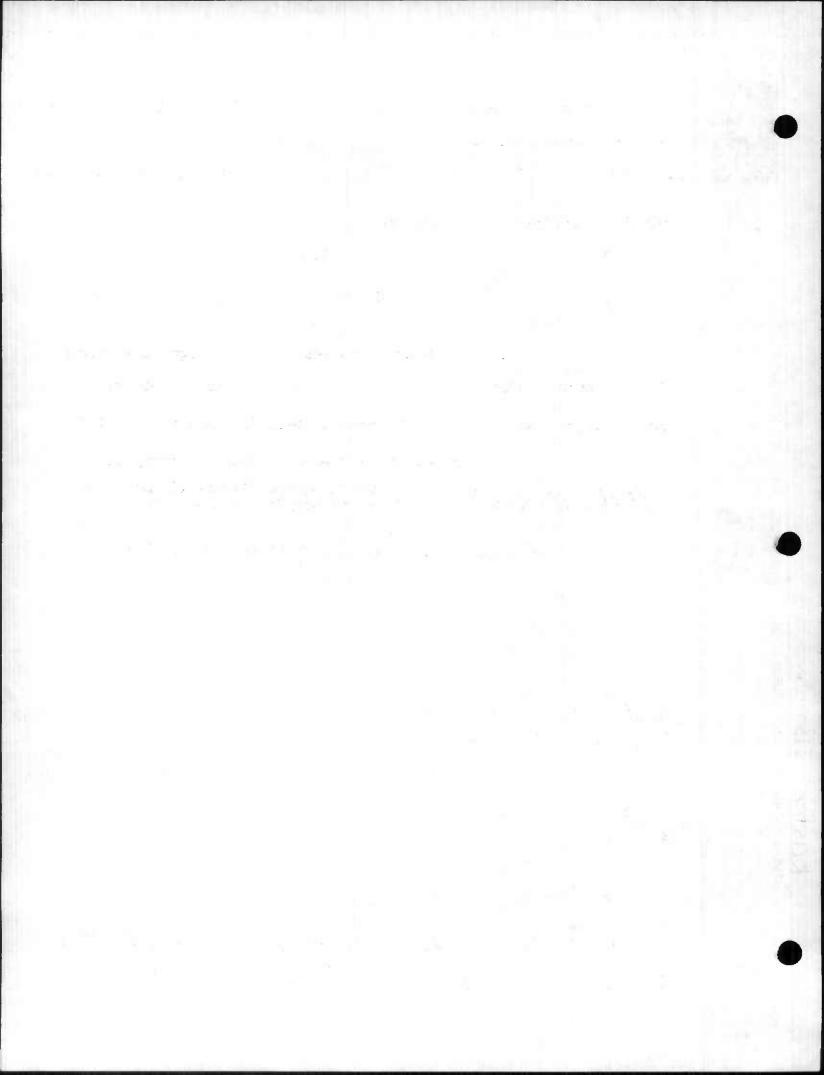
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						arylaria /	Certificate of		Reg	J. No.	5 211	10
		Physic	ian	1. Decedant's Nema (First, Middla, Li					2. Data of Death	26	Vone .	a of Death
		/Medi			Juanita Marguerite Keister 4a. Facility Nema (If not Institution, give street and number) 4b. City, Town,					4c. County		00,111
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		Funeral Director		5. Social Security Number 6. 226-12-0693		ga (In yrs. last I	oirthday) If Undar 1 Yeer Months Deys	If Undar 24 Hrs.	8. Data of Birth (Month, Day,) Jan 10			ta or Foreign
Maryland 21215-0020		end wo		Usual Rasidence of Decedant 10a. Stata 10b. County		10c. City, To	wn or Location					a City Limits
		filed within 72 hours effer death with the Meryland Hygiene. ther than "natural", or items 23s or 28s-f show ent, the Medical Experience maint or notified.	tor	Maryland Har	ford	Fdc	gewood				The state of	as 2No
			Director	10e. Street and Numbar	LOIG	1200	10f. Zip Coda		100	. Citizan of V	What Country?	
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	ary		1	19a. fntomant's Name/Raiationship			9b. Mailing Addrass (Streat	t and Number or Rui	al Routa Number, (City or Town,	Stata, Zip Coda)	
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	ore	of He		20a. Mathod of Disposition 1 ★Burial 2 ☐ Cramation 3 ☐	Ramovai from State	20b. Placa cemai	of Disposition (Nama of lary, cramatory or other pla	ce)	Dete 20	c. Location -	City or Town, Stata	
	Ë	permit. Peges 1 and 2 should Department of Heelih and Men Important: If Item 27 is marke any injury or other traumatic ORCS.		4 Donation 5 Other (Spaci	(y)	Mt. C	nristian Cema	etery 6	/30/98	Joppa,	Maryland	d
Ba	Baltimore,			21. Signatura of Funaral Sarvice Licensea 22. Name end Addrass of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part : Entar ha disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrast, Initaryal Batween Onset and Death Onset and Death								
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daat	Je.		1. Marital Status		12. Was Decede	ent Ever In	U,S.	13. Was De	cedent of F	lispenic Origin en, Maxican, P	? (Specif	fy Yes or No	U11,	ited S	erican Indi	en,
Baltimore, Maryland 21215-0020 permit. Pagas 1 and 2 should be filed within 72 hours aftar death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or any injury or other traumatic event, the Moores Examination	2		1⊠ Never Merried 2☐ 3☐ Widowed 4☐ Divo		Armed Force 1 Yes 2 If Yes, Give Yeer or Dete	No No			specify Cubo		uerto Ric	can, etc.)		Bleck, Wh	ite, etc. Black	
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that the ed by			HYPERTENS	LON,	DIABETES	, ASI	'HMA,	ANEMIA	A, DEME	ENTIA		10	Yee 2	No 3□F	Probably	4 SUnknown
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Tec	du	-													of deeth?	
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Physician: The This cartificata trail director, pag	Be		5. Wes case referred to med	lical						26. Plece of	Death (C	Check only o	one)			
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if or Attending P effer death. I Director: Affar t d In by tha funara	Certification:		3 ☐ Sulcide 6 ☐ Co	ild not be	28a. Place of	Injury - At I	nome fam				28f	1 ocation /	Street and	Number or F	aural Route	Number
or efter	T		4 ☐ Homicide Gar	arminad	building,	atc. (Spec	ify)	1, 31,001, 1001	tory, office		201	City or To	vn, Stete)	redition of the	iorar i iodio	74011001,
To the Hospital or / within 24 hours efter To the Funeral Dire complately filled in t	edical Co	2	29e. Certifier 12. Cartl (Check only one)	lying Phy caf Exam	elclan: To tha be fner: On the basis	of examin	owledge, o	deeth occurre	ed et the tin	ne, dete end pi pinion, daeth o	lace, end	due to the	cause(s) e date end p	nd manner a leca, end du	s stated.	use(s)
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s	tate	3	1. Dete filed (Month, Day, Ye	ar)	32. Regi	strer's Sign	eture							0		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 29, Irene Georgia Lubonski 1998 June 11:25 pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Riverdale Pr 5721 64th Place Prince George's Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F Yrs. Director 219-48-7145 49 Sept. 15, 1948 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if fern 27 is marked other than "hatural", or hems 23a or 28a-f show any lojury or other traumatic event, the Medical Examinat must be notified at PAGE. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Prince George's Riverdale Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5721 64th Place 20737 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 11 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Nama (First, Middle, Last) Be (Unavailable) Ruth Conedia Dovel 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles S. Lubonski, Jr.-Husband 5721 64th Place, Riverdale, Maryland 20737 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Ramoval from State 4 Donation 5 Other (Specific 7/3/98 Brentwood, Maryland Fort Lincoln Cemetery 21. Signature of Funeral Service Lic 22. Name and Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part 1. Enter the strong or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart folders. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel diseesa or condition resulting in death) /Medical a METASTATIC COLON CARCINOMA 1 YEAR Examiner Due to (or as a consequence of): Examiner physician and the buriel-trensit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of) 60 USB signed by the e 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ۵ Division of Vital Records, 24b. Were autopsy findings available prior to completion of ceuse of death? been sig 24a. Wes an autopsy performed? Completed has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: director, 25. Wes case reterred to medical examiner? Be 28. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 \$\times\$ Residence 6 Other (Specify) 1 ☐ Yes 2 No 20 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Certification: 1 Natural 5 Pending 1 Yes 2 No death. investigation Director: A 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) eftar 4 I Homicide hin 24 hours of the Funeral Di hipletaly filled in Continuing Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner es stated.

Maddan Framiner: On the basis of axagination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier edical (Check only On the basis of axa nation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signatura 29c, Licensa number D08254 July 1, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Drive, #205, Greenbelt, MD Thomas A. Bensinger, MD,

State Registrar 31. Date filed (Month, Day, Year) JUL 02 1

32. Registrar's Signature

DHMH 16 Rev 6/95





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1 Decedent's Nama (First Middle Last) 2. Dete of Death Day 1998 LARKINS June 24 5:57 PM RICHARD 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctors' Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) 15€M 2□F Yrs. 219-01-9372 80 Nov, 18, 1917 Maryland Usual Rasidence of Dacedent 10b County 10c. City. Town or Location 10d. Insida City Limits 1 Yea 2 No Prince George's Bowie 10f. Zip Code 10g. Citizan of What Country? 12904 Duckettown Road 20719 USA 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 14 Race - American Indian Black, Whita, atc. 1 □ Yas 2 □ No If Yes, Giva Yeer or Detes: 1 □ Navar Married 2 □ Married 1 Yas 2 No Specify: Specify: Black 3€Widowed 4 □ Divorced 15. Decedent's Education (Spacify only highast grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Clerk Government 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middla, Last) Horace Larkins Nina Johnson 19b. Melling Addrass (Streat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19e. Informant'a Name/Relationship (Type, Print) India Harrison/Stepdaughter 8720 Maple Avenue, Bowie, Maryland 20720 20b. Plece of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata Date 1 Burial 2 □ Cremation 3 □ Ramoval from Stata Ft. Lincoln Cemetery 4 ☐ Donetion 5 ☐ Othar (Spacify) 6/30/98 Brentwood, Maryland 21. Signeture of Funarai Service Licenses 22. Nama and Addrass of Facility J. B. JENKINS FUNERAL HOME Charles & Downson 7474 Landover Road, Landover, Maryland 20785 23a. Part1 Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onsat and Death Immediata Causa (Final disease or condition rasulting in deeth) CARDIAC ARREST MINUTES TEARS DISPAIR CORONALY ARTERY Due to (or as a consequence of): HOURS SERTIC SHUCK. Dua to (or as a consaquance of): . HYPER OSMOLAR STATE HOUKS-23b. Did tobacco use contributa to the cause of death? 1 Yss 2 000 3 Probably 4 Unknown ACCIDENT 24b. Wera autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? HYPERTENSION 1 ☐ Yas 2 ☐ No A BETES MELLITUS 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 M ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 28d. Describe how injury occurred

Sequentially list conditions, if any, laeding to immadiata ceuse. Enter Undarfying Ceusa (Diseasa or Injury that initieted avents rasulting in daath) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

CEREBRAL VASCULAR

BSSENSIAL

25. Was cesa rafarred to medicel exeminer?

1□ Yas 2□ No

5 Panding invastigation

6 Could not be determined

28a. Dete of Injury (Month, Day Year)

28b Time of

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Spacify)

28c. Injury at Work? 1 Yas 2 No

29a. Cartifian

27. Mannar of Death 1 Natural 2 \(\text{\text{Accidant}}\)

3 Suicida

4 Homicida

Certifying Physician: To the bast of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of cegliller

29c. Licansa number

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Physician

/Medical

Examiner

Funeral

Director

with the Merylend r 28a-f ahow

permit. Peges 1 and 2 should be filed within 72 hours efter death with Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23s or any injury or other traumstic event, the Medical Examiner must be in page.

Physician /Medical

Examiner

physician end the buriel-transit

signed by the a d be detached t

certificate has b irector, page 2 s

al or Attending Physician: T s aftar death. Il Director: Aftar this certificat ed in by the funeral director, p

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

Examiner

Physician/Medical

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11. Meritel Status

10e. Street and Number

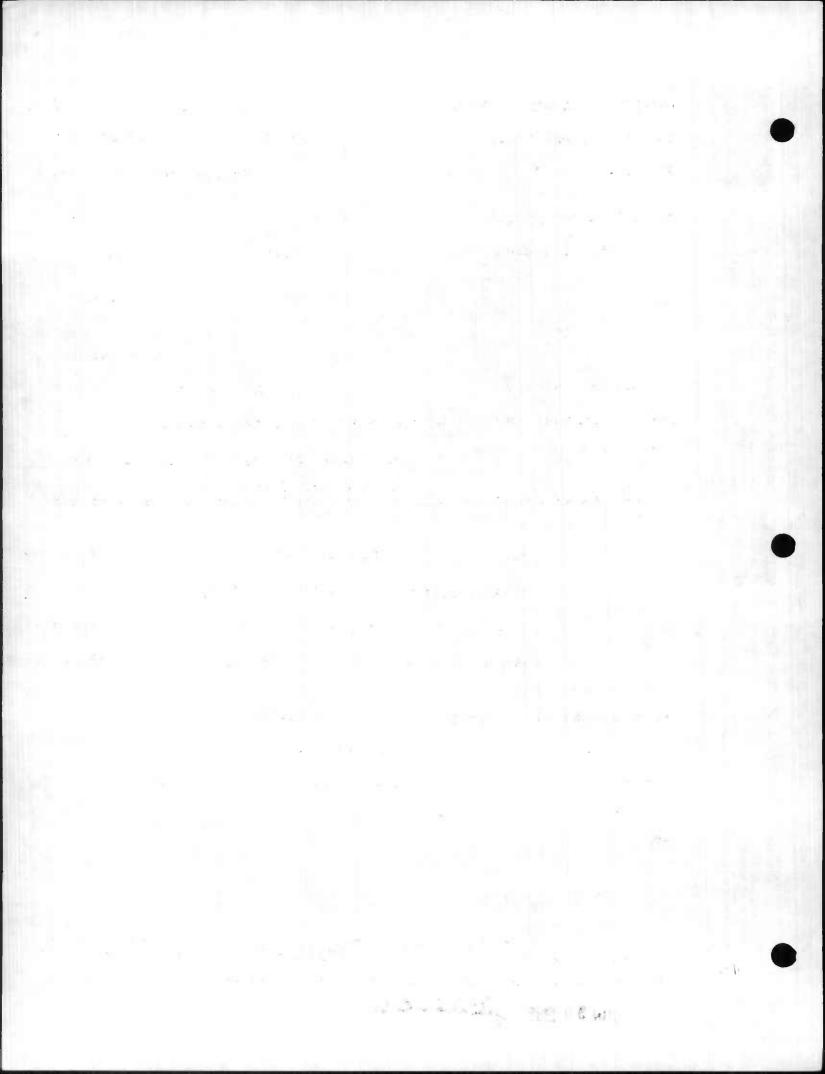
11th

30. Name and autress of person who complated causa of daeth (Itam 23e) (Type, Print)

George Bone, M.D. 1100 Merchantile Lane, Suite 135, Largo MD 20774

State Registrar 31. Data filed (Month, Day, Year) JUN 3 0 1998





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Alice Irene June 29, Lawhorne 1998 8:10 A.M. 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctor's Community Hospital 8. Date of Birth (Month, Day, Year)
Nov. 2, 19 If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2\ F Months Days Hours Min. 218-20-1606 95 1902 Maryland Usual Residence of Decedant 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2√ No Maryland Prince George's Riverdale 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20737 U.S.A. 6800 Riverdale Road 14. Race - American Indian, Biack, White, atc. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Owner Supermarket 12 17 Fathar's Name /First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth John Benjamin Alsop Sarah Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6411 Ivy Lane, #414, Greenbelt, Maryland 20770 Stanley S. Pickett - Son 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Siate 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State Fort Lincoln Cemetery 7/1/98 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility 21. Signature of Funeral Service Licensee Gasch's Funeral Home, 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Failure disease or condition resulting in death) Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disaase or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Congestive Heart Failure Dua to (or as a consequence of): Cardiac Arrhythmia Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 📉 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) No 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred

Physician /Medical Examiner the death certificate be executed

permit. Pege Department of Important: If any injury or once.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Peges 1 and 2 should be filed within 72 hours efter nent of Health and Mental thygiene.
Int: If them 27 Is marked other than "natural", or itea into or other trauments ovent, its least at the interior or other trauments.

Baltimore, Maryland 21215-0020

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Physician/Medicai À Completed Be Lo funeral Certification: After f or Attending after death. Director: Aft

Division of Vital Records, P.O. Box 68760,

The law

Physician

Attending

A 24 hours

To the Within 2 To the

25. Was cese referred to medical examiner? 1 Yes (2) 27. Manner of Deat 1 Natural 5 Pending 2 Accident

3 Suicide 4 D Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

29b. Signature and title of certifier

invastigation 6 Could not ba determined

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, streat, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. Licensa number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

June 29, 1998

28f. Location (Straet and Number or Rural Route Number, City or Town, State)

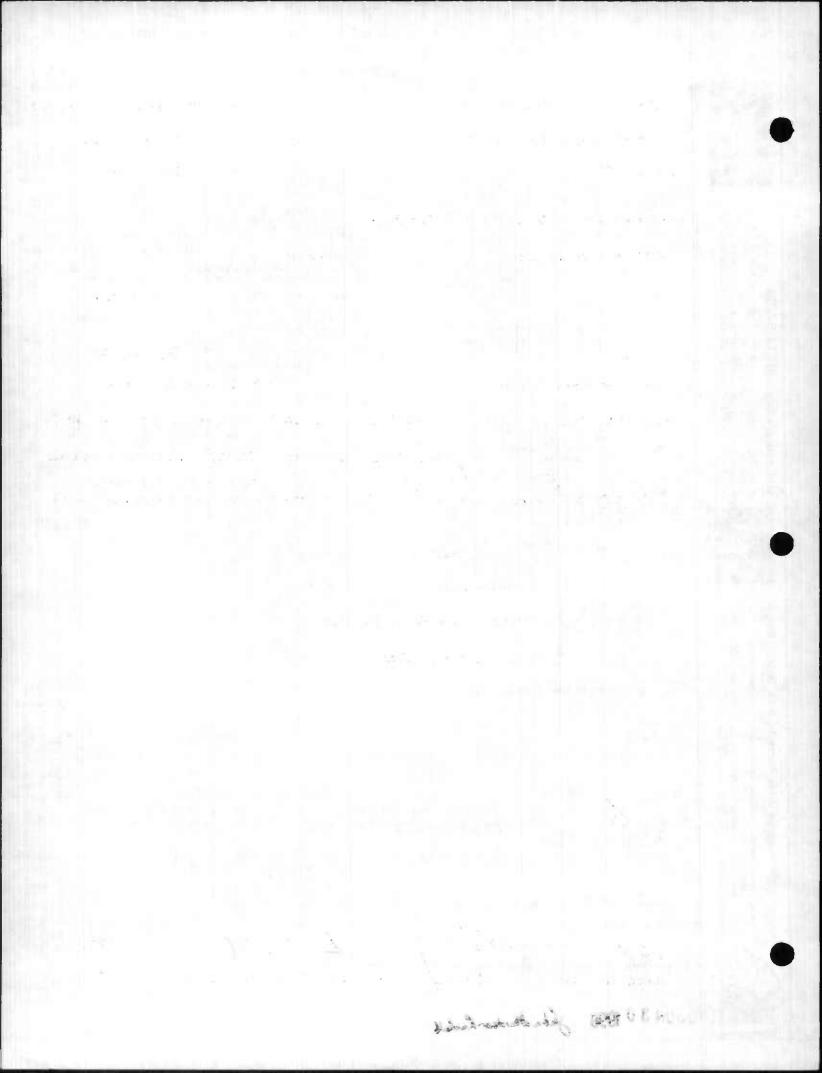
30. Name and address of person who completed cause of death (flore 200) (Type, Print)

Richard J. Lilly, M.D., 5804 Bultimore Avenue, Hyattsville, Maryland 31. Date filed (Month, Day, Year)

State Registrar

Medical





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day Ves **JOHN** MONROE JUNE 26 1998 12:27pm 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) SHOCK TRAMA CENTER If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6 Sex Min 1 X M 2 □ F Months Days Hours Yrs. 213-25-8964 21 March 12, 1977 Maryland Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits Y Yes 2 No Maryland Dorchester Hurlock 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 521 Academy Street 21643 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes; Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Analyst Banking 18 Mother's Name (First Middle Meiden Sumeme) 17 Father's Name (First Middle Last) John William Monroe Jamie Lee Beales 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Jamie Lee Monroe/Mother 521 Academy St., Hurlock, MD 21643 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-29 Cambridge Crematory Cambridge, MD 22, Name and Address of Facility 21. Signetyre of Funerel Service Licensee Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 Dunwell Willen 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Batween Onset and Death Immediata Causa (Final diseasa or condition resulting In death) a MULTISYSTEM ORGAN FAILURE 2 days Dua to (or as a consequence of): HYPOVOLEMIC SHOCK AND CLOSED HEAD 4 days Sequentially list conditions, if any, laading to immediata ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): MOTOR VEHICLE ACCIDENT 5 DAYS ON APPROVED BY HEAT EXAMINER Due to (or as a consequence of): 23b. Did tobacco ues contributa to the cause of death? er algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2 No 1 Yas 25 No case referred to medical iner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 8 Other (Specify)

Physician /Medical Examiner

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permit. Pages Depertment of Important: If it eny Injury or o

Physician

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Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland neart of health and Mentel Hyglene. In the Maryland the Hyglene with: If them 27 le marked other than "natural", or items 23s or 28s-f show any or other treumstic event, the Medical Evant near than 12st and 1st

Examiner physicien end the bunal-transit Completed by Physician/Medical Be

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	Part II. Oth
	25. Was c

1 Vas 2 No

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6 Could not be datarmined

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 - Homicida

(Check only one)

CO. DOX	at the death certif	by the ettending stached for use e	
records, 1	e law requires tha	hes been signed ge 2 should be de	
ion of vital necords, P.O. Box	nding Physician: The law requires that the death certif ath.	r: Affer this certificate hes been signed by the ettending ie funeral director, page 2 should be detached for use e	

Certification: To 27. Manner of Death

Medical

To the Hospital or Attend within 24 hours after deat To the Funeral Director: completely filled in by the

	State
Reg	istrar

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, data and place, end dua to the causa(s) and manner stated. 29d. Dete signed (Month, Dev. Year) 29b. Signeture end title of certifier 29c. License number D52369 Care Critical 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) BALTIMORE S. GREENE

28c. Injury at Work?

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and mannar as stated.

1 ☐ Yes 2X No

28d. Dascribe how injury occurred

struck dump truck

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28b. Time of

unknown

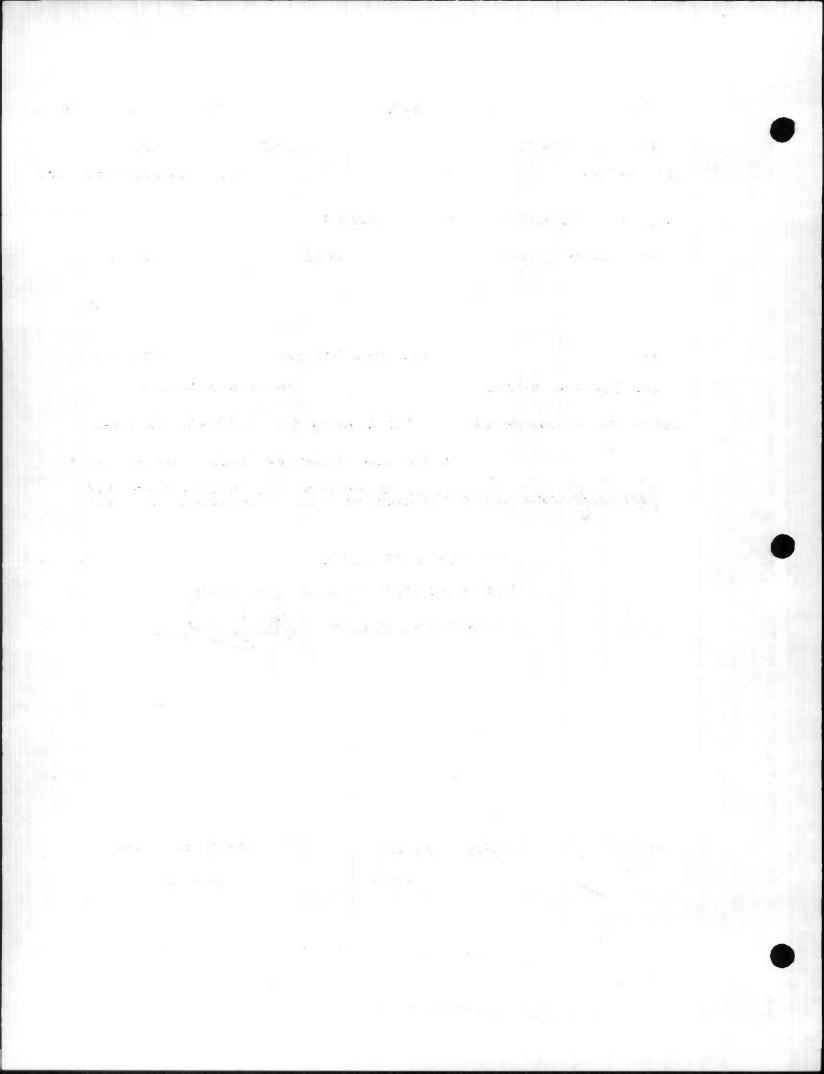
street

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Aggistrar's Signatura

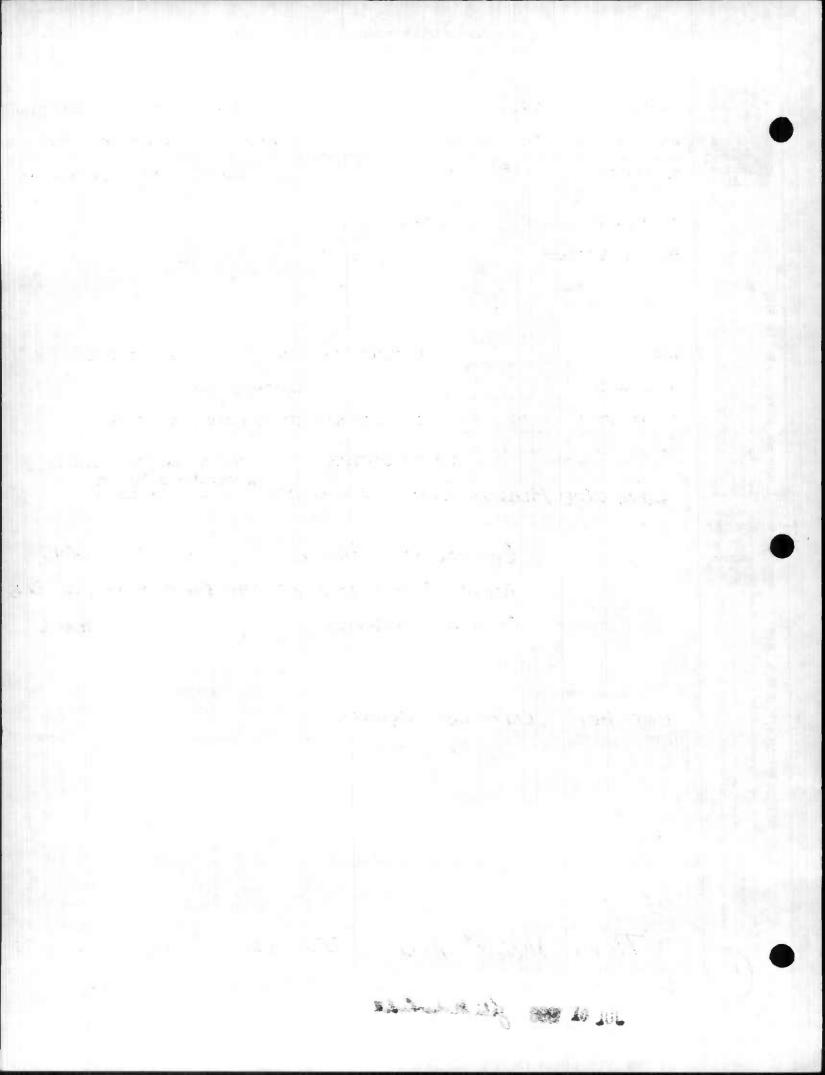
28a. Date of Injury (Month, Day Year)

6/22/98



State of Maryland / Department of Health and Mental Hygiene

			Ce	lillicate	OI	Dealli			Reg. No.		
								Month	Day	Yaar	3. Tima of Death
						41. Oh. T.				-15 -4	3:25 p.m.
					1						COLINTY
			s. last birthday	If Undar							aca (Stata or Foreign
			Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		
Usual Rasidance of Dacedant		, , ,			-			January	191743	NOT CI	Caronna
10a. Stata 10b. Cour	nty	10c. (City, Town or Lo	ocation						10	Od. Insida City Limits
Maryland Monts	gomery	9	Silver	Spring							1 Yas 2 No
10e. Street and Number									10g. Citizan of V	Vhat Coun	try?
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11. Marital Status			U,S. 13.	Was Deced	ant of H	lispanic On	gin? (Spe	ecity Yas or No	14. Race		
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Part II. Other significant cond	itions contributing to	death but not r	esulting in tha	ındarlying ca	ausa giv	ren in Part I	l.	23b. Dld	tobacco uss co	ntribute to	the cause of death?
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axaminar/ 1 ☐ Yas 2 🔀 No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DO	A Oth	nar: 4 🗆 Nu	ursing Ho	ma 5 Rasi	danca 8 Oth	ar (Specif	v)
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State of Maryland / Department of Health and Mental Hygiene

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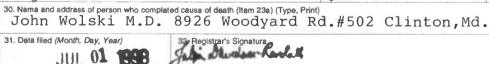
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Physician /Medical Examiner		23a. Part1. Entar tha disaasa, or co shock, or haart failura. List or immediete Ceusa (Final disaasa or condition rasulting in death)	a. Corc. b. Seen						ardiac or ri	aspiratory a	rrest,		Approximata Interval Between Onset and Death 3-27-97
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Hospital (24 hours a Funeral Dietely filled indical Ce	-	29a. Cartifier (Check only one) Check only one)	Physician: To the best aminer: On the basis of end manner si	f axamina	wiedga, daai ition and/or ir	th occurred nvastigation	at tha ti	ma, data and opinion, daath	place, and occurred	I dua to tha at tha tima,	causa(s) and ma date and place,	annar as : and dua !	stated. to tha cause(s)

State

31. Deta filed (Month, Day, Year)

29b. Signature and title of certifier

JUL 01 1998



29c. Licanse number

817994

29d. Dete signed (Month, Day, Year)

June 30,1998

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Year **Physician** JUNE 28, GLORIA ODESSA McDOWELL 1998 5:25 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Days Hours 1 M 2 X F Yrs. **Director** 097-28-2216 MAR. 5, 1931 WEST VIRGINIA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental hygiena. Important: If item 27 is marked other than "naturel", or heme 23a or 28a-f show eny injury or other traumatic event, if a Madical Examinating mounted as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MARYLAND PRINCE GEORGE'S PALMER PARK 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1829 RAY LEONARD ROAD 20785 Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yas 2 No If Yes, Give Yaar or Datas: 1 ☐ Naver Marriad 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: 3 Widowed 4 Divorced BLACK à Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLASSIFIED OPERATOR NEWSPAPER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be HAYWOOD JONES MARGUERITE BRANCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) WALTER E. JAMES, JR., SON 4117 WARNER AVENUE, #C-8, LANDOVER HILLS, MD 20784 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7/1/98 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CREMATORY BRENTWOOD, MARYLAND 21. Signature of Funeral Services 22. Name and Address of Fecility
FORT LINCOLN FUNERAL HOME orus 0 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician Immediate Cause (Finat disease or condition resulting in death) /Medical CARDIORSPIRMONY ARRES Examiner Due to (or es e consequence of): 24 hours Examine NRYMONI physician and the burial-transit law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Box 68760, Physician/Medical 88 PRMANSION 950 ed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Denknown Division of Vital Records, þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of death? certificate has t NO Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA 1 Inpatient 2 R/Outpatient this funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) Aftar 5 Pending Investigation 1 WNatural 1 Yes 2 No 2 Accident sfter death Director: 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5 hours a 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completaly f (Check only one) 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Pay, Year) 29b. Signatura and title of Certifier 29c. License number

State Registrar

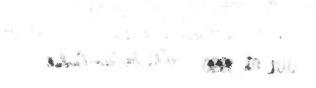
31. Date filed (Month, Day, Year) JUL 01 1998

SAMUEL ALLEYNE, M.D.,

7100 BALTIMORE AVENUE, #510, COLLEGE PARK, MARYLAND 32 Registrar's Signeture

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

D25766



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 0845 SUNE 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth MEM. If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Dey tar LORD ixa. Harlow 8. Dete of Birth (Month, Dey, Year) Soft 29, 1923 if Under 1 Year 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1 M 2 F Months Deys 218-26-0064 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits Yes 2 No HARFORD AURE DEGLACE 10e. Street and Number 10a. Citizen of Whet Country? 559/2 21878 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No if Yes, Give Year or Dates: Never Merried 2 Married 1 Yes 2 No Specify Specify: BIACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4005e Koepor 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 4NNix SAMUE1 Williams 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Houre do Grace Date 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Havre de Corace, MI) Jamos Cem 22. Name and Address of Facility BOURD FUND Migran Lewis 54 552 23a Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onset end Deeth Tyo cardeal sufarction 140 Immediete Cause (Finel diseese or condition resulting in death) Due to (or as e consequenca of) Due to (or es a consequence of) Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Metastan's. houlls 24b. Were autopsy findings aveileble prior to 24a. Was an autopsy performed? completion of cause of deeth? 2 0 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

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Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Haalib and Mantal Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ahow any lajury or other traumatic event, the Modical Examine must be notified at

Baltimore, Maryland 21215-0020

Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in deeth) Lest Physician/Medical 96 955

by

Completed

Be

Certification:

edicai

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☑Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how Injury occurred 28c. Injury et Work?

28e. Dete of Injury (Month, Dev Year) 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and pleca, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier

5 Pending

Whihan

investigation

6 Couid not be determined

1 Yes 2 No

27. Menner of Deeth

1 Maturel

2 Accident

4 Homicide

3 Suicide

29e. Certifier

29c. License number 32600 29d. Date signed (Month, Dey, Yeer) 119128

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

MD

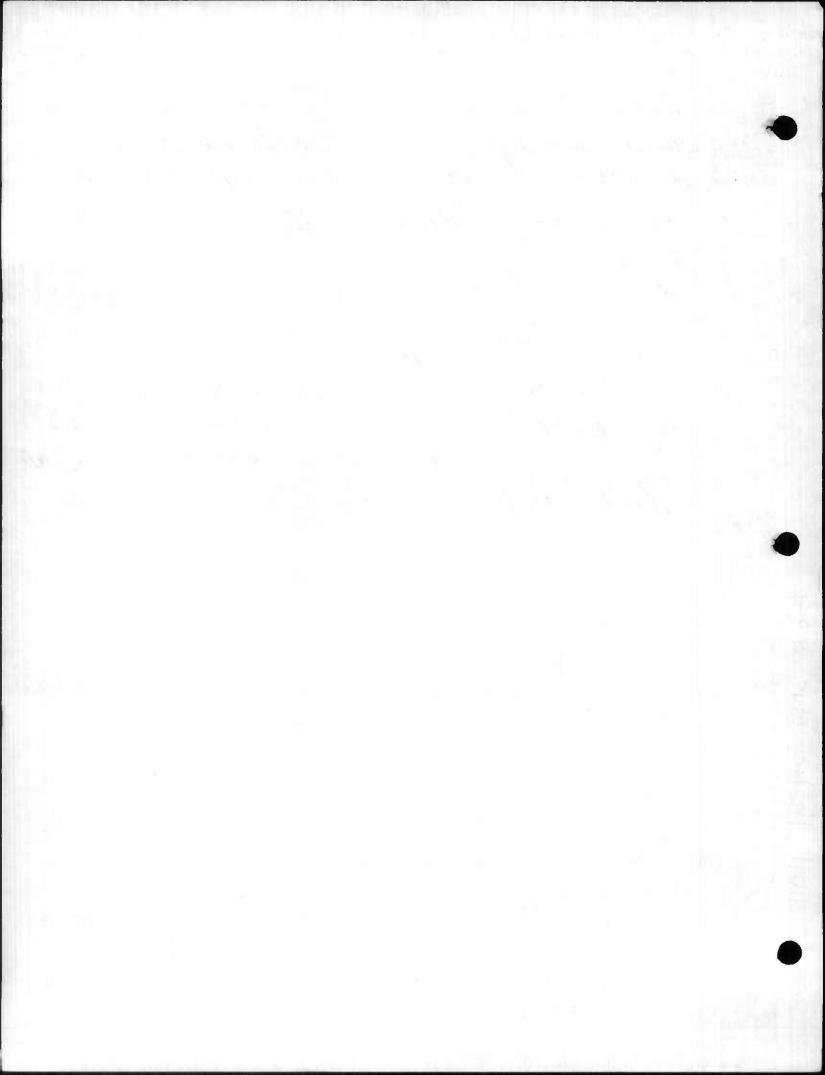
Kammidin Milhans no 703 Revolutionst arrele Gran 11 21028 31. Dete filed (Month, Day, Year)
JUN 3 0 1998

State Registrar

62. Registrer's Signature

after death Director: J

To the Hospital of within 24 hours at To the Funeral Discompletely tilled it



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yaar **Physician** MEALY IRVIN CHARLES 98 04=58 Am لمور 30 /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL HAZCOLD FALLSTON EN GALLDTON If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Month, Day.
(Month, Day. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 100M 2□ F 217-24-9932 Yrs. 66 Director 1932 New York Usual Rasidence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yas XXNo Director Abingdon Harford 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ð 238 3811 Longley Road U.S.A. 21009 Completed by Funeral Herris 2 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. be filed within 72 hours after 1 Xas 2 No if Yas, Give Yaar or Datas: 21 Yrs. 1 □ Nevar Married 2 □ Married ò Baltimore, Maryland 21215-0020 1 Yas 2√2 No Specify: Specify: Black 3€36Vidowed 4 □ Divorcad "natural" 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) al Hygiene. Eiementary/Secondary (0-12) Collage (1-4or 5+) Military U. S. Air Force 17. Father's Nama (First, Middla, Last) to if Hern 27 is marked 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Charles F. Nealy Camille Brooks Pages 1 and 2 should 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Mr. Michael Nealy (Son) 555 Pierce St. #908-B Albany, Calif. 20a. Method of Disposition 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) Department of Important: If any Injury or once. Spesutia Cemetery 7/3/98 Perryman, Maryland 22. Nama and Addrass of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Exparai Sarvice Licansas algo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line Approximate interval Between Onsat and Death **Physician** /Medical A SCU D immadiate Causa (Final disaasa or condition rasulting in death) **Examiner** Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. attending physician for use as the huria Physician/Medical Dua to (or as a consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? been signed by the should be datech 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of daath? hes 1 Tyas 2 No 1 Yas 2 No this cartificata spital or Attending Physician: The hours after death.
Ineral Director: After this carificate y filled in by the funeral director, pa Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 28c. injury at Work? 28d. Dascribe how injury occurred Certification: 27. Mannar of Death 28b. Tima of 5 Panding injury 1 69 Naturai 1 Yes 2₽No invastigation MA NA 2 Accidant 6 Could not be datermined 3 Suicide 28a. Placa of injury - Af home, farm, sfreef, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifia: 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) DME OCME 1013098 30. Name and address of person who completed causa of death (item 23a) (Type, Print) GPRABHU 4108796564

218 FULCOND AN BELAIR MD 21014

DHMH 16 Rev 6/95

State

Registrar

M. O.

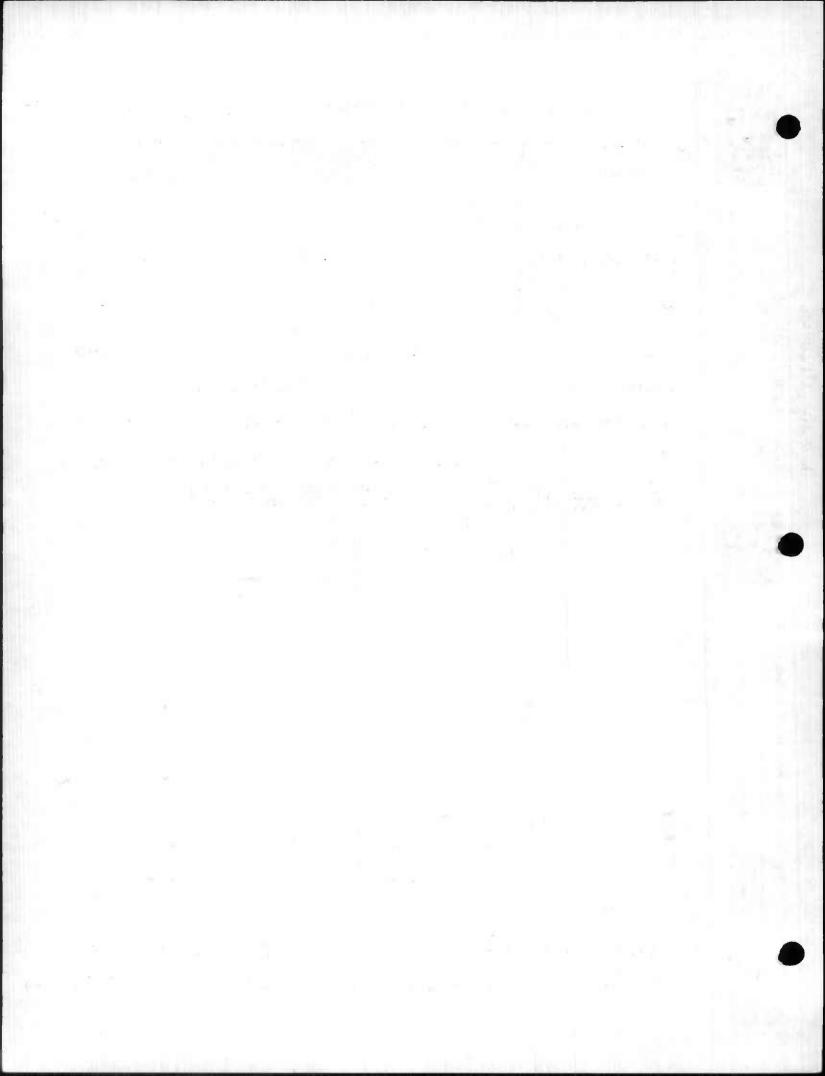
1998

31. Data filed (Month, Day, Year)

JUL 2

32. Registrar's Signature

Jedyr, Charles



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mary Ellen Padgett June 1998 16:40P /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Prince George's Hospital Cheverly Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funerai** 1□ M 2□XF 370-30-1219 68 Yrs Director Aug Georgia Usuel Residence of Decadent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show traumatic event, the Magical Examiner must be notified at Maryland Prince George's 1☐Yes 2☐No Director Capitol Heights 10e. Streef and Number 10f. Zip Code 10g. Citizen of Whef Country? ò 6411 Wilburn Drive 20743 238 United States Funeral filed within 72 hours after death Hems 12. Was Decedeni Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. African 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Detes: "natural", or 21215-0020 1 Tes 2 No Specify. by 3 Widowed 4 Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within nent of Health end Mental Hygiene. int: If Item 27 Is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Business Education Teacher Federal Government Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be To Charlie C. Sapp Bertha Henry 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health e : If Itam 27 Is or other trai Calvin F. Padgett, Sr./Husband 6411 Wilburn Dr.; Capitol Heights, MD 20743 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - Cliy or Town, State permit. Page Department of Important: If any Injury or Ft. Lincoln Cemetery 6/30/98 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Washington, D.C. 20019 ella 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es a consequenca of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760. Physician/Medical esn P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown þ Division of Vital Records, 24b. Were eutopsy findings aveilable prior to completion of cause of death? pege 2 should Completed 24e. Was an autopsy performed? 1 Yes 2 No 25. Wes case referred to medical examiner?
1 ☐ Yes 2 No Be 28. Piace of Deeth (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this In by the funeral 27. Manner of Death 1 X Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After ? 5 Pending s efter death. 1 Yes 2 No 2 Accident investigetion 6 Could not be determined 3 Suicide 28e. Placa of injury - Ai home, farm, sireei, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funeral [Hospital Medical 29a. Certifies Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as atated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner steted. 29b. Signature and title of cartifier, 29d. Dete signed (Month, Day, Year) Cheverly TERWILLIGER

DHMH 16 Rev 6/95

State Registrar

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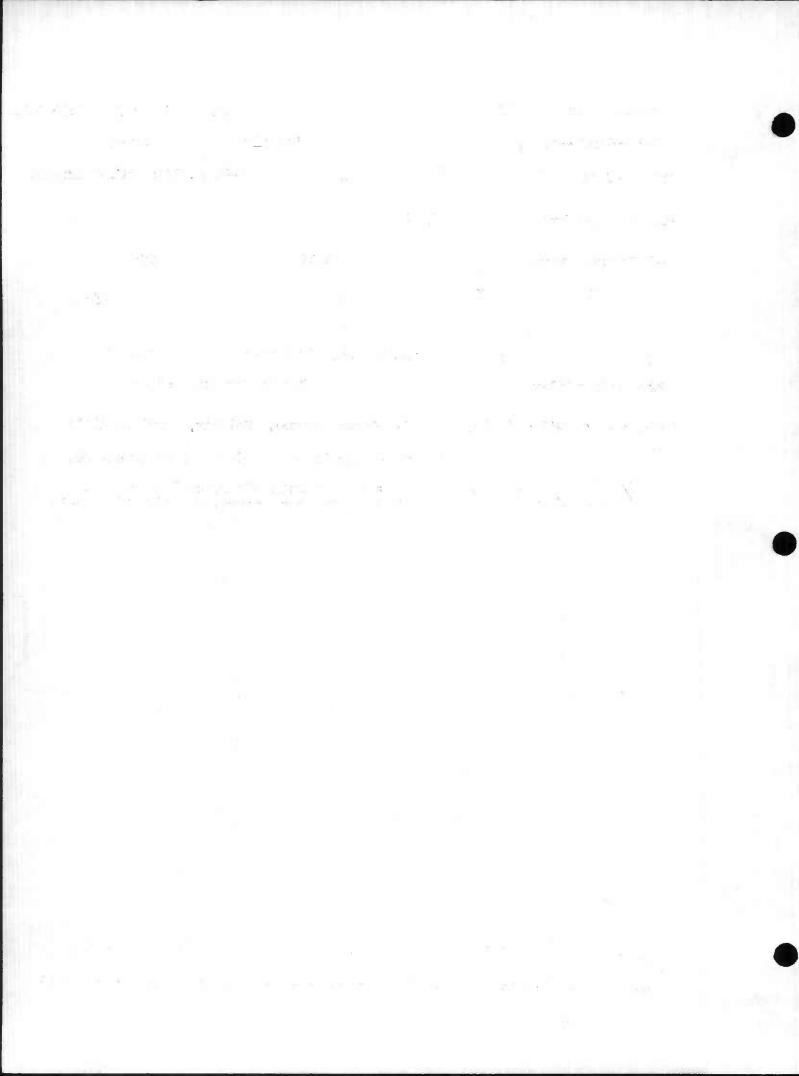
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To the Funeral Dir completely filled in Medical Cert		29a. Certifier 154 Certifying P (Check only one)	hysician: To the beat of miner: On the basis of and mannar sta	axamination	edge, death occ n and/or invasti	curred at the t Igation, in my	ime, date and place opinion, deeth occu	e, and dua to tha urred at the time,	cause(a) and made end place,	anner as atated and due to the	ceusa(s)
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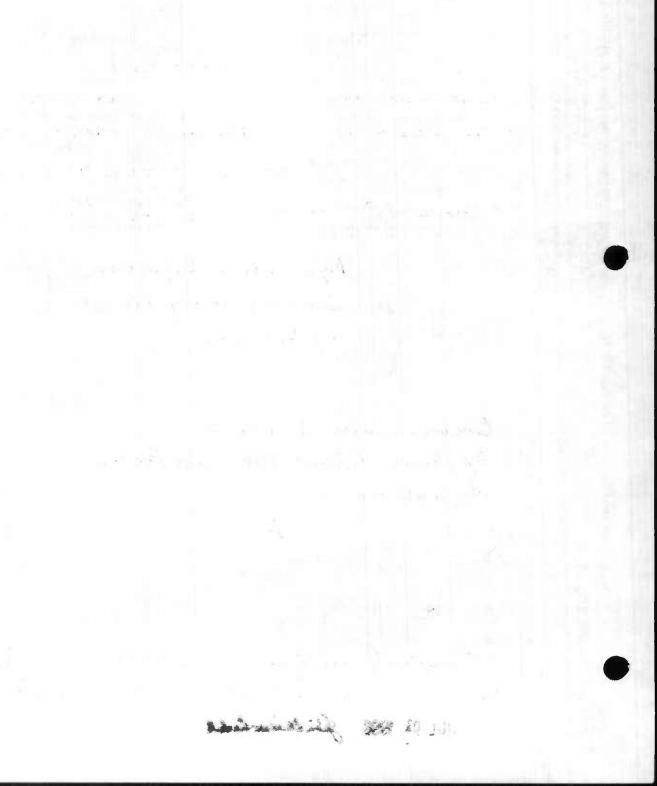
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	To Be Completed by Physician/Me	Part II. Other significant conditions of Part II. Other significant conditions	Hospital: 1 inpatient : 28a. Data of Injury (Month, Day Year 28a. Plece of Injury - A building, atc. (Sp. //siclan: To the best of my iner: On tha basis of axam	ER/Outpatien 28b. Tima of Injury at homa, farm, streecity) knowledge, deeth	at 3 DOA Other 28c. Inju Wo	26. Piace of Diar: 4□ Nursing ry at rk? Yes 2□ No	24a. Waiperfi 24a. Waiperfi 1 — eath (Check only Homa 5	Yas 20 No san autopsyormed? Yas 20 No ona) Idance 6 Oth how Injury occur Street and Numb wn, Stata) ceusa(s) and ma date and place,	3 Probably 4 24b. Wara sutopsy available prior completion of of death? 1 Yes 2 er (Specify) red per or Rural Routa Nural Routa Steled.	Junknow findings to cause No
	edical Certification: To Be Completed by Physician/Me	Part II. Other significant conditions on the conditions of the con	Hospital: 1 inpatient : 28a. Data of Injury (Month, Day Year 28a. Plece of Injury - A building, atc. (Sp. //siclan: To the best of my iner: On tha basis of axam	ER/Outpatien 28b. Tima of Injury at homa, farm, streecity) knowledge, deeth	at 3 DOA Other 28c. Inju Wo M 1 ceet, factory, office	26. Piace of Diar: 4 Nursing ry at rk? Yes 2 No me, dete and piac spinlon, death occ sa number	24a. Waiperfi 24a. Waiperfi 1 — eath (Check only Homa 5	Yas 20 No s an autopsyormed? Yas 20 No ona) Idance 6 Oth how Injury occur Street and Numb wn, Stata) ceusa(s) and ma date and place, 29d. Data signe	3 Probably 4 24b. Wara sutopsy available prior completion of of death? 1 Yes 2 er (Specify) red per or Rural Routa Nuranner as steted, and dua to the couse of Month, Day, Year)	Junknow findings to cause No
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Me	Part II. Other significant conditions on the conditions of the con	Hospital: 1 inpatient : 28a. Data of Injury (Month, Day Year 28a. Plece of Injury - A building, atc. (Sp. reiclan: To the best of my iner: On the basis of axam and mannar stated.	2 ER/Outpatien 28b. Tima of Injury t homa, farm, streecify) knowledge, deeth	at 3 DOA Office 28c. Inju Wo 1 Docurred at the It restigation, in my control 29c. Licent 0 2	26. Piace of Diar: 4 Nursing ry at rk? Yes 2 No me, dete and piace pinion, daath occur sa number	24a. Waiperfi 24a. Waiperfi 1 □ eath (Check only Homa 5 Ras 28d. Dascribe 28f. Location City or To	Yas 2No san autopsyormed? Yas 2N No ona) idance 6 Oth how injury occur Street and Numb wn, Stata) ceusa(s) and ma date and place, 29d. Data signe	3 Probably 4 24b. Wara sutopsy available prior completion of of death? 1 Yes 2 er (Specify) red per or Rurai Routa Nuranner as steled. and dua to the ceuse(findings to cause No

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	State of M	laryland / [Department of I Certificate of			iene	21784
	Decedent'a Name (First, Middle, Last)		0.00		2. Date of Death		3. Time of Death
Physician	Christine Elizabeth	Quand	er Simmon	S	June 2	Day Ye	
/Medical Examiner	4a Facility Name (If not institution, give street end number			4b. City, Town, or Lo		4c. County of I	
CAdminer	Prince George's Hosp	ital		Cheve	rly	Prince	George's
Funeral		ge (In yrs. lest bii	thdey) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Dey,		Birthplace (State or Foreign Country)
Director	218-34-5503 1□M ★★	97	Yrs. Months Days	Hours Min.	May 5,		Maryland
D	Uaual Residence of Decedent	1					
arylar show	10a. State 10b. County	10c. City, Tow					10d. Inside City Limits
vith the Ma or 28a-f s be notified	Maryland Prince George's		Uppe:	r Marlboro)		1 Yes 2 No
or 2	10e. Street and Number		10f. Zip Code		10	og. Citizen of Whe	
	15500 Marlboro Pike			20772			USA
	11. Marital Status 12. Wes Deceden Armed Forces	f Ever in U,S.	13. Wes Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indien, While, etc.
S also also also also also also also also	If Yes Give	ξNo	1 ☐ Yes 2 🛣 No			Specify:	Black
5-UCZU 72 hours efter natural; or its	3 M Widowed 4 Divorced Year or Dates						
21215-U ed within 72 ho ygiene. wr than "naturn rt, the Wedgest!	15. Decedent's Education (Specify only highest grede completed)	16a	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work	ing	16b. Kind of Busin	ess/Industry
Man district	Elementery/Secondary (0-12) College (1-4or	5+)					
Maryland 21215-0020 d 2 should be filed within 72 hours ef th end Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	6th 17. Father's Name (First, Middle, Last)		Cafeteria M	anager 18. Mother's Name	e (First Middle A		ernment
and be filed that Hyg ed other event, Be C	William Dominic Quander				Greenfie:		
Eshould be end Mental s marked o humatic event To Be	19a, Informent's Name/Relationship (Type, Print)	101	o. Mailing Address (Stree				to Zin Code)
Ma d2 sl h en h en r ls r traur	William D. Simnons/Son						Maryland 20747
C TO N L	20e. Method of Disposition		Disposition (Neme of	olen bilve		20c. Location - City	
0 F 0 F 0	1 Burial 2 ☐ Cremation 3 ☐ Removal from State	cemete	ry, cremetory or other ple				
Bartin Demit. Pe Departmen mportant: Inty Injury	4 Donetion 5 Other (Specify)	Maryla	and Veteran		7/6/98	Cheltenh	am, Maryland
Barri Permit. Departm Importa eny Inju	21. Signature of Funeral Service Licensee		22. Name end Addr	and also a Disc	neral Hor	m _O	
	Charles & Downson		7474 Ta	andover ro	nad Land	dover M	arvland 20785
Physician /Medical	23a. Part1/Enter the disease, or complications that cause shock, or heer feilure. List only one ceuse on each					est,	Approximete Interval Between Onset and Deeth
Examiner	disease or condition resulting in death)	Due to (or as a	al Infa consequence of): Artery consequence of):	retion			d In
وَ ا	(Due to (or as a	4 4	D-10-10			5 VIVI
axecuted and iel-transit	Sequentially list conditions	Due to for as a	consequence of):	8.14436			3 412
be avacuted sician and bunel-transit		Perten					10415
0 70 0	that initiated events		consequence of):				7.2
death certificate e ettending physical for use es the	resulting in death) Last	,					
box of sath certiff et ending for use es	d						
The lew requires that the death certificate has been signed by the ettending primage 2 should be deteched for use as the Completed by Physician/Medi	Part II. Other significant conditions contributing to death	but not resulting i	n the underlying cause o	iven in Pert I.	23b. Dld to	bacco use contri	bute to the ceuse of deeth?
that the de ed by the deteched	-4	-			1 Y		Probably 4 Unknown
S, F es that igned t be det	Cerebro vascular 1	Accid.	ent				
I HECONDS, P.O. The lew requires that the late has been signed by the page 2 should be detected.	7	1	115	-	24a. Was ar		4b. Were autopsy findings aveilable prior to
DIVISION OF VITAL RECORDS, or Attanding Physician: The lew requires the first death. Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by	Dysphagia, GASTA	OSION	14 lube 1	redev	penom	1001	completion of ceuse of death?
The lew ate has page 2	In continence				1□ Ye	s 2 No	1 ☐ Yes 2 ☐ No
VITAL INICIAN The Contificate rector, pag	25. Was case referred to medical			Of Diseased Door			10 165 20 160
VISION OF VITA Attending Physician: Indeath. sector: After this cardific by the funeral director, iffication: To Be (25. Was case referred to medical exeminer? 1 Yes 2 No Hospital: 1 Inpat	tient 2 DER/O	utaging all post of	26. Plece of Deat		e) enca 6 □Other ((Cnarity)
Phys Phys stal di	27. Menner of Death 28a. Date of In	jury 28b.	Time of 28c. Inju	4 U Nursing Ho		ow Injury occurred	Spacity)
DIVISION OF Hospital or Attending P n.24 hours after death. The Funeral Director: After to pletely filled in by the funeral edical Certification:	1) Natural 5 Pending (Month, D	ley Year)		ork? Yes 2 No			
Attendition of the function of	3 Suicide 6 Could not be 28e Place of I	njury - At home. fa	arm, streef, facfory, office				or Rurel Route Number,
after after or A	4 Homicide determined building, 6	etc. (Specify)			City or Town		
Hospital 24 hours Funeral tely filled	29a. Certifier 1 Certifying Phyefcfan: To the bes	t of my knowledge	e death occurred at the t	ime date and place.	and due to the ca	use(s) and mann	er as stated.
Hoa 24 h Fun etely	(Check only one) 2 Medical Examiner: On the basis and manners	of examination ar	d/or investigation, in my	opinion, death occur	red et the time, de	ate and place, and	due to the cause(s)
To the Hospital or Attent within 24 hours after deal To the Funeral Director: completely filled in by the Medical Certifical	29b. Signature and title of certifier		29c. Licen	ise number	25	9d. Date signed (A	Month, Day, Year)
F 3 F 8		tr				Λ	
	Jagu Ane	no	13	0111		yune	27,1978
(10)	30. Name and eddress of person www.completed ceuse of	death (Item 23a)	(Type, Print) Pitsea Dr	R. 11	11- 111	1 20700	- /2-
	Gary W Jones MD 31. Date filed (Month, Dey, Year) 32. Begis	trade Signature	ilsen Ur	HELISVI	ue 'na	00100	1/57
State Registrar	JUL 01 1998	trar's Signature	Rule				
negistrar	201 AT 1220						

DHMH 16 Rev 6/95



					Certificate	of Health and North Death	Re	g. No.) 4	1/03
Physic /Medi	cai	1. Decedent's Neme (First, Middle, Zelda	Marie		Stout		2. Dete of Deeth Month June	25	1498	3. Time of Death 12:47A
Examir Funeral Director	ner		nity Hospi	,	inthday) If Under 1 Y Yrs. Months Di	4b. City, Town, or Lo Lanham eer If Under 24 Hrs. eys Hours Min.	8. Dete of Birth (Month, Day,	Year)	9. Birthple	ece (Stete or Foreign
το .		220–58–7601 Usuel Residence of Decedent					Oct. 28	, 1937		
The Marylan 28a-f show notfiled at	Director	10a. Stete 10b. County Maryland Prince 10e. Street end Number	Georges		m or Location	rie .	10	og. Citizen of N		d. Inside City Limits 1X Yes 2 □ No
th with	ai Di	3911 Church Rd.			2072			U.S.A.	mot oount	,
urs after dea af, or items Examiner m	by Funeral	11. Maritel Stetus 1 □ Never Married 2 ★ Merried 3 □ Widowed 4 □ Divorcad	12. Wes Deceder Armed Force 1 1 Yes 25 If Yes, Give Year or Dates	₹No	13. Was Decedent If Yes, specify (of Hispenic Origin? (Sp Cuban, Mexican, Puerto No <i>Specify:</i>	ecify Yes or No- Rican, etc.)		ea - America ck, White, e	tc.
within 72 ho ene. then "rietur the Medical.	Completed	15. Decedent's (Specify only highest Elementery/Secondary (0-12)	grede completed) College (1-4o	r 5+)		ccupetion one during most of work stired)	ing	16b. Kind of Bi	usiness/Indu	-
Hygo other	Be Co	12 17. Fether's Name (First, Middle, La	st)	H	omemaker	18. Mother's Name	e (First, Middle, M	N/Z feiden Sumen		
should by Menta marked matic e	TOE	Paul Burkhardt				Anna Mi	ullen			
20日本書		19a. Informent's Neme/Reletionship				reet end Number or Run				Code)
f Health Hem 27 other to	i	Harry L. Stout (1 20e. Method of Disposition		20b. Pleca	11 Church of Disposition (Neme of the company or other		ellville Dete 2	POc. Location -		m, Stete
Page mart of ant: If ury or		1 ☐ Buriel 2 ☐ Cremetion 3 4 ☐ Conetion 5 ☐ Other (Spe			ont Mem. C	1	/29/98 Da	avidsor	ville	, MD
Departition of the post of the		21. Signature of Funeral Service Lit			Rendon/H	ddress of Fecility	l Homo			
Physician /Medicai Examiner		23e. Pert1. Erher the diseese, or cl shock, or heart feilure. List or Immediate Ceuse (Final diseese or condition resulting in death)				dyfing, such es cardlec				Approximete Interval Between Onset end Deeth
feath certificate be executed attending physician and d for use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Inlitiated events resulting in deeth) Lest	b		consequence of):					
b death he atten	Physician/M	Pert II. Other significant conditions	contributing to deeth	but not resulting	n the underlying cause	given in Pert I.	23b. Did tol	bacco uae co	ntribute to	the cause of death?
es that the decigned by the a	by Phy						1 □ Ye	s 2□No	3 Prob	ably 4 🗗 Onknown
aw requir	Completed		<u> </u>				24e. Wes en perform		evai	re autopsy findings ileble prior to apletion of cause eeth?
The ate		05 11/1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-						s 2000	10	Yes 2□ No
Physician: this certificant rai director,	To Be	25. Wes case referred to medical exeminer? 1 Yes 2 No	Hospitel: 1 Inpa	tient 2 ER/O	utpatient 3 DOA	Other:	h (Check only one		er (Specify)	
ing Ph. After thi funeral	Certification: 1	27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigat 3 Sulcide 6 Could no	28a. Date of In (Month, E	jury Jay Year) 28b.	Time of 28c.	Injury et Work? 1 Yes 2 No	28d. Describe ho	w Injury occur	red	
To the Hospital or Attend within 24 hours after deal! To the Funeral Director:		4 Homlcide determine			erm, street, factory, of		28f. Location (Str City or Town,	, State)		
e Hos 1 24 ho e Fun detely	edical	(Check only one)	rnyaician: To the besis aminer: On the basis and menner:	of examination er	e, deeth occurred et the ad/or investigetion, in r	e time, dete end plece, ny opinion, death occurr	end due to the ce red et the time, de	use(s) end me te end pleca,	and due to	ited. the cause(s)
To the vithin ?	Ň	290. Signature and title of certifier	1	~	29c. Lic	ense number	29	d. Dete sibne	d (Month, D	ey, Year)
(, , ,	0	7		216410		-1-	كالحالا	18
6		30. Neme end eddress of person when the second seco	MD, 750	onalt a	VIER PARK	WAY, SUI	TE 105,	GREEN	BEUT	MD 2077
Sta Registr		JUN 3 0 199	38	trer's Signature	dell				Ę	

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Year June 27, 1998 15:20 Leo W. Spriggs /Medicai 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince George's Ade1phi Heartland Healthcare Center If Under 1 Yeer | If Under 24 Hrs. Birthpiece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey)
76 Yrs. 8. Dete of Birth (Month, Dey, May 10, **Funerai** Deys Hours tXXM 2□ F Yrs. Mary l'and Director 219-12-1101 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "naturel", or flems 23a or 28a-f show ury or other treumetic event, the Medical Examiner man be notified at 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits D.C. Washington XX Yes 2 No Director 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 20011 331 Upshur Street, N.W. Funerai 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2)(No It Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 20 No Specify: Black. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) Coilege (1-4or 5+) Lumber Industry 12th grade Supervisor 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Helen Pinkney John Spriggs 19a. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 331 Upshur Street, N.W. Washington, D.C. 20011 Mrs. Catherine R. Jenkins (Daughter) 20b. Plece of Disposition (Name of Date 20c. Location - City or Town, Stete Maryland National Memorial Park July 3,1998 Laurel, Maryland permit. Pages Department of important: If it eny injury or o 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility.
Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. nt1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, nock, or heart tellure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medicai Immediete Cause (Final diseese or condition resulting in death) . Cerebral Glioma Few Weeks Examine Due to (or es e consequence of): Examiner siclan end bunal-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury thet Initieted events resulting In deeth) Lest Due to (or es e consequence ot): physician s the buria Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): for use Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cerebrovascular Accident þ 24b. Were autopsy findings eveileble prior to completion of cause ot death? Completed 24e. Wes en eutopsy performed? Hypertension Chronic Renal Insufficiency 1 ☐ Yes 2XXNo 1 Yes XX No Hospital or Attending Physicien: 24 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director, Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4XX ursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2€No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. tnjury et Work? 1 XX Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) and manner as stated.
2 Madical Examtner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) end manner stated. pletely (Check only one) within 2 To the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Da. Gupta, mi June 28, 1998 D46398 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) G. Gupta, MD 121 Congressional Lane, #409, Rockville, Maryland 20852 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JUN 3 U 1998 Registrar

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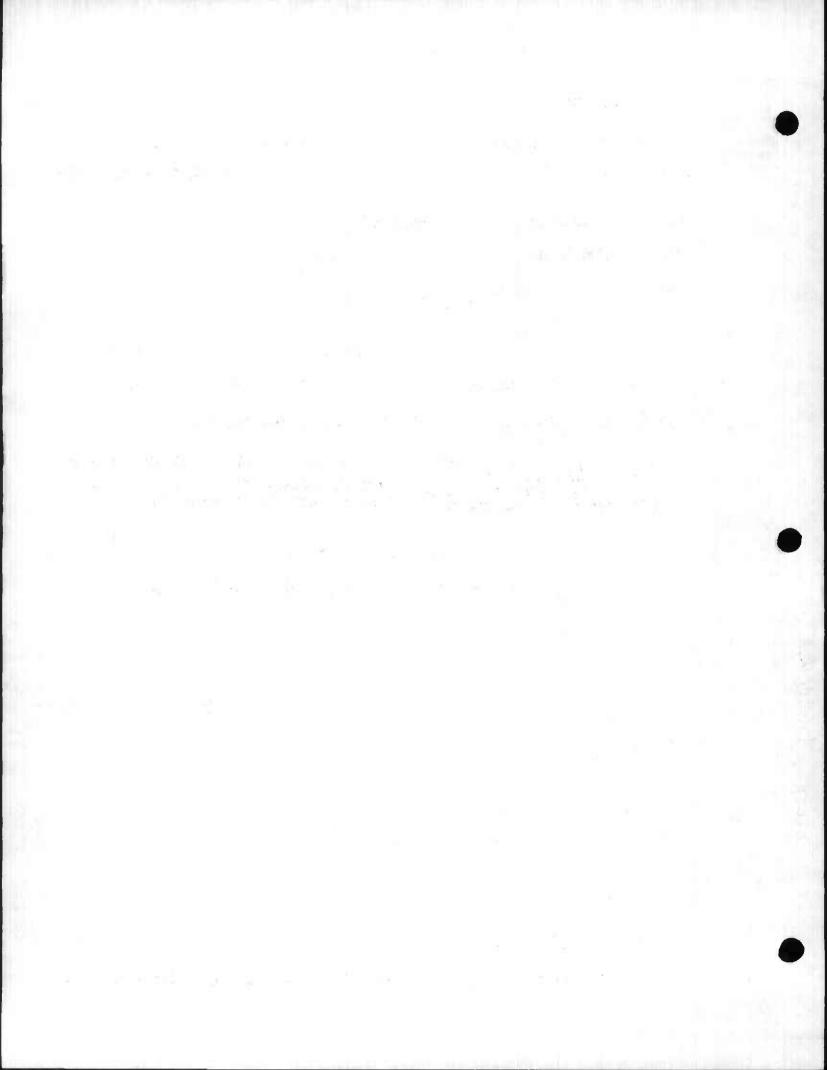
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	Usual F	Residence o	Decedent 10b. Count	he			10c. City, 1	Tours or L	ocation								
runeral Director	100	yland			eoro	re's	TOC. CHY, I	TOWIT OF L		ando	war					10	od. inside City L
	10e St	reet end Nu		-		,			10f. Zip		7761			10a Citi	izen of Wh	het Count	41
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ĺ		/Cno.	15. Decede	nt's Ed	ucation	otad)		16a. Dece	dant's Usua	l Occupa	ation	t of work	ina	16b. Ki	ind of Bus	inass/Ind	lustry
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		ethod of Dis		-,			20b. Plac	ce of Dispe	osition (Nam	na of		, 100	Date	-	ocation - C		
	12	Burial 2	☐ Cremation 5 ☐ Other (from State			matory or of od Cem				5/29/98	o U	ohin	~ t ^ -	D C
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State of Maryland / Department of Health and Mental Hygiene Q 🙊

						Certificat		Death		Reg. No.	1 6	1700		
	Physic		Decedent's Name (First, Middle, Las					2. Data of Month		eath Day Year		3. Time of Death		
	/Medi		BUFORD JACKSON SPICER						June	27	1998	10:21 Am		
į.	Exami	ner							c. City, Town, or Location of Death 4c. County of Death					
			Fallston General Hospital 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Und				1 Year	Fallsto	allston Harford nder 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign					
	Funeral Director	Director		XM 2□ F				Hours Min.	(Month, Day	nth, Day, Year)		Birthplace (State or Foreign Country) Virginia		
	yland		10a. State 10b. County					10	0d. Inside City Limits					
68760, Balt	Se-1 s		Maryland Harfo									1 ☐ Yes 21 No		
	with the		10e. Street and Number			10f. Zip Code				0g. Citizen of What Cou		try?		
	s 23	eral	2122 A Nuttal Ave	NUC 12. Was Decedent	Ever in II C	12 Was Dags		LO40	nasih. Van az Na	US	SA se - America	no lo dos		
	ours ofter death with the Marylar al, or items 23a or 28s-1 show Examiner must be notified at	by Funeral	Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Yaar or Dates:	No	1□ Vac		Hispanic Origin? (S lan, Mexican, Puert Specify:	o Rican, etc.)	Specify	ck, White, a	atc.		
	should be filed within 72 ho nd Mental Hygiene. merked other than "natur umatic event, tre Mexical	eted	15. Decedent's Ed	lucation		Decedent's Usual Occup		pation	king	16b. Kind of B				
		Completed	Elementery/Secondary (0-12)	College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)			Anig .					
			11 17. Father's Name (First, Middle, Last)	17. Father's Name (First, Middle, Last)			Inventory Clerk 18. Mother's Na			-	ept. of Army			
			Luther Samuel	Spice	r				Viola	Anders	-/			
									er or Rural Route Number, City or Town, State, Zip Code)					
	1 end 2 Heelth e em 27 is		Boyd J. Spicer - B	rother	2	122 A Nu	tta.	l Avenue,	Edgewood	d, MD	21040)		
	permit. Pege Department o Important: If any injury or any injury or		20a. Method of Disposition 12 Burial 2 Cremation 3 1		20b. Place of	of Disposition (Namery, crematory or o	ne of		Date	20c. Location	City or To	wn, State		
			4 Donation 5 Other (Specify		Bel A	ir Memor	ial	Grdns.	7/1/98	Bel Air	. Mar	vland		
			4 Donation 5 Other, (Specify) Bel Air Memorial Grdns. 7/1/98 Bel Air, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A.											
			1317 Cokesbury Rd., Abingdon, MD 21009											
			23a Partt / Enter the disease, or comp about, or heart failure. / List only o	lications that caused ne cause on eech lir	the death. Do	not enter the mod	le of dyl	ng, such as cardiac	or respiratory ar	rast,		Approximate Interval Between Onsat and Death		
	Physician /Medical		1 1/1											
	Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of):									ntiroun		
	v .≝		_	Acut				occudial	in for	natron				
	end end -trans	Examiner	Sequentially list conditions,	7	occo d. sc.									
	The law requires that the death certificate be executed its has been signed by the ettending physician end page 2 should be deteched for use as the burlat-transit		Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury	С										
		Aedical	that Initiated events rasulting in daath) Last		Due to (or as a	consequance of):								
		icla	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given						23b. Dld t	obacco use co	ntribute to	the cause of death?		
		Physician/						1 Yes 2□ N			CARL STATE OF THE			
	es tha	by	try per fertiters						,					
	v require been sign should b	Completed	swatcing						24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?			liable prior to		
	To the Hospital or Attending Physicien: The law within 24 hours efter death. Within 24 burerel Director: After this certificate has b completely filled in by the funeral director, page 2 s	mpl										leath?		
a									1 U Y	,	1	Yes 2 No		
5		o Be	25. Was case referred to medical examiner?	26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify)										
of		TO :L	27. Menner of Death	28a. Date of Injur	y 28b.	b. Time of 28c.		ry at	28d. Describe how Injury occurre					
ion		Certification:	1 Natural 5 Pending 2 Accident Investigation	ion (Month, Day Year) Injury Work? Libe ad 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Spacify)				Vork?						
Division		tifle	3 ☐ Suicide 6 ☐ Could not be determined				28f. Location (Streat and Number or Rural Route Number, City or Town, State)							
۵	urs often or or or or or or or or or or or or or		20.00											
	Hosp 24 ho Fun etely	edicai	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(s) end manner as stated. (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(s) end manner stated. Certifying Physicien: To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(s) end manner as stated.									ated. the ceuse(s)		
	To the comple	Me	29b. Signature and titla of certifiar 29c. Licanse number 29d. Data signed (Month, Day, Year)									Day, Year)		
			1 CC MD 0375						7 June 27, 1998					
	\		30 Manne and address of person who co		eath (Item 23e)	(Type, Print)		A .	_		1			
	1		David C. Mb	in my) 10	x plum	tro	e Pd s	+ 110,	Bel	Hir	WD		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registe	r's Signatur	irdall								



			State o	f Marylan	,	partment Prtificate		lealth and N Death	Mental Hy	/giene 🧷 (Reg. No.	2 1	189
		1. Decedent's Nema (First, Middle	, Last)						2. Data of D	eath		3. Tima of Deeth
Physici /Medic		MARGURITE MATIL	DA BOWMAN	SPRIGG	S				July	$0^{\text{Day}}, 19$	98	8:24AM
Examin		4e. Facility Neme (If not Institution Civista Medi						4b. City, Town, or L La P1	ata	Cha	rles	
Funeral Director		5. Social Security Number 220-74-6469	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs.) 80	est birthda Yrs.	y) If Under Months	Year Days	If Undar 24 Hrs. Hours Min.	8. Data of B. (Month, D. SEPT.	irth ey, Year) 2,1917	9. Birthpiac Country MARYI.A	a (Stete or Foreign ND
and w		Usuei Rasidance of Decedent 10a. Stata 10b. County		10c. City	. Town or	Location					104	Inaida City Limits
the Maryla 28a-1 show notified at	Director	MARYLAND CHARL 10e. Street and Number	ES		GAH		Parls.			40- 00		1 XYas 2 No
With with		6445 MASON SPRI	NGS ROAD			10f. Zip (206	40		10g. Citizen of UNITED		
ours after death with the Maryla all, or terms 23s or 28s-f shor Examiner must be notified at	Funeral	11. Maritel Status 1 Never Married 2 Marri	12. Wes Dace Armed For	dant Evar in U, rces? 2 🔀 No	S. 13	. Wes Decede If Yas, speci	int of H	lispanic Orlgin? (Sp an, Mexican, Puarto	pecify Yas or N Rican, atc.)		ce - Amarican ck, Whita, etc	Indian,
Fal., c	by	3 Widowed 4 □ Divorced	If Yas, Giv Yaar or De	a etes:		1□ Yas 2	Ľ¥ No	Specify:		Specif	BLACK	
72 h natu	eted	15. Dacedant (Specify only highes	s Education		16a. Dec	edant's Usual	Occup done	etion during most of work	kina	16b. Kind of B	usinass/Indus	try
of be illed within 72 hours a sital Hygiens: ted other than "natural", or cevent, the Medical Exam	Completed	Eiemantary/Secondery (0-12)	Coilage (1	-4or 5+)		IE MAKE		during most of world)		PRIVA	TE	
Hygin Bher ant, II		6TH GRADE 17. Fathar's Nema (First, Middle, I	ast)		HOP	IE MAKE	K	18. Mothar's Nam	a (First, Middle			
uld be Mental riked o dic ev	To Be	ALEXANDER BOWMAN	,					LUVENIA F			,	
2 sho and h is me		19e. informent's Neme/Ralationsh		AUGHTER				end Number or Ru INDIAN HI			, Stete, Zip Co 20640	ode)
f of He If Nerr or oth		20a. Method of Disposition 1 Durial 2 Cramation 4 Donation 5 Other (Sp	3 □Ramoval from 5	20b. P	iaca of Dispersion	position (Nem emetory or ott	e of ner plea	Ce)	Data 7/7/98	20c. Location		
permit. Pa Departmen Important: any injury once.		21. Signature of Furieral Service I	icensee to	Johns	or I	ZZ Name and THORNTO	Addre N F	UNERAL HO	OME, P.	Α.		
Physician		IA C. THORN 23a. Part1. Enter tha disaasa, or shock, or haert failura. List o				3439 LI ntar tha moda	VIN of dyir	IGSTON ROA	AD, IND or raspiratory	IAN HEAD	Ar	20640 pproximeta arvai Between nsat and Death
/Medical Examiner	_	Immediata Causa (Final disaesa or condition resulting in deeth)	a. Y	MyoCo	as a cons	equenca of):	n	garcf				
law requires that the death certificate be executed as been signed by the attending physician and 2 should be deteched for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or injury thet initiated avants rasulting in deeth) Last	c. Alt.(vosdo	as a cons	equenca of):	D	Slase				
death e atte	sicia	Part II. Other significant condition	is contributing to de	ath but not rasu	iting In the	undartving ca	usa div	en in Part I.	23b. Did	tobacco usa co	entributa to th	e causa of death?
ires that the de signed by the d be deteched	by Phys	Circhosis			/	undanying ou	uou giv	on an one.		Yes 2□ No		ly 4 □ Unknown
Physician: The law requires this certificate has been signered director, page 2 should be or	Completed		<i>V</i>						24a. Wa perf	s an autopsy ormed?	avaiia	autopsy findings ble prior to ation of cause th?
The la	် ပ								1 🗆	Yas 2□No	1 🗆 Y	as 2 No
ysician: The	Be	25. Was case refarred to medical axaminar?						26. Piaca of Daa	th (Check only	one)		
this ei di	2	1 ☐ Yes 2 ☑ No			ER/Outpati		_	4 LI Nursing H		idanca 6 Oth		
The fact	Certification:	27. Mennar of Death 1 Naturai 5 Panding 2 Accidant invastig 3 Suicida 6 Could n	ation	of injury th, Dey Year)	28b. Tima Injury	of 28	c. Injur Wor	yat rk? Yas 2 □ No	28d. Describe	how injury occur	rred	
ital or Attendius after death.ral Director: Alled in by the fe		4 Homicide datamii	ned 28e. Place	of Injury - At ho ng, atc. (Specify	me, farm, s	straat, factory,	office			(Street end Numi own, Stete)	ber or Rural Re	oute Number,
To the Hospital of within 24 hours at To the Funeral Discompletely filled it	edicai	29a. Cartifier 1 ☐ Cartifying (Check only one)	Phyeician: To the i xaminar: On the ba and menn	sis of axaminat	viedga, daa ion end/or i	ith occurred a invastigation, i	tha tin	ma, data and piaca, pinion, daath occur	end due to the red at the time	ceusa(s) and ma , dete end piace,	annar as stata and dua to the	d. a causa(s)
カラ ヤー	Σ	29b. Signatura and titia of certifier				200	Linna	a number		004 0-4	d (Month, De)	14 1

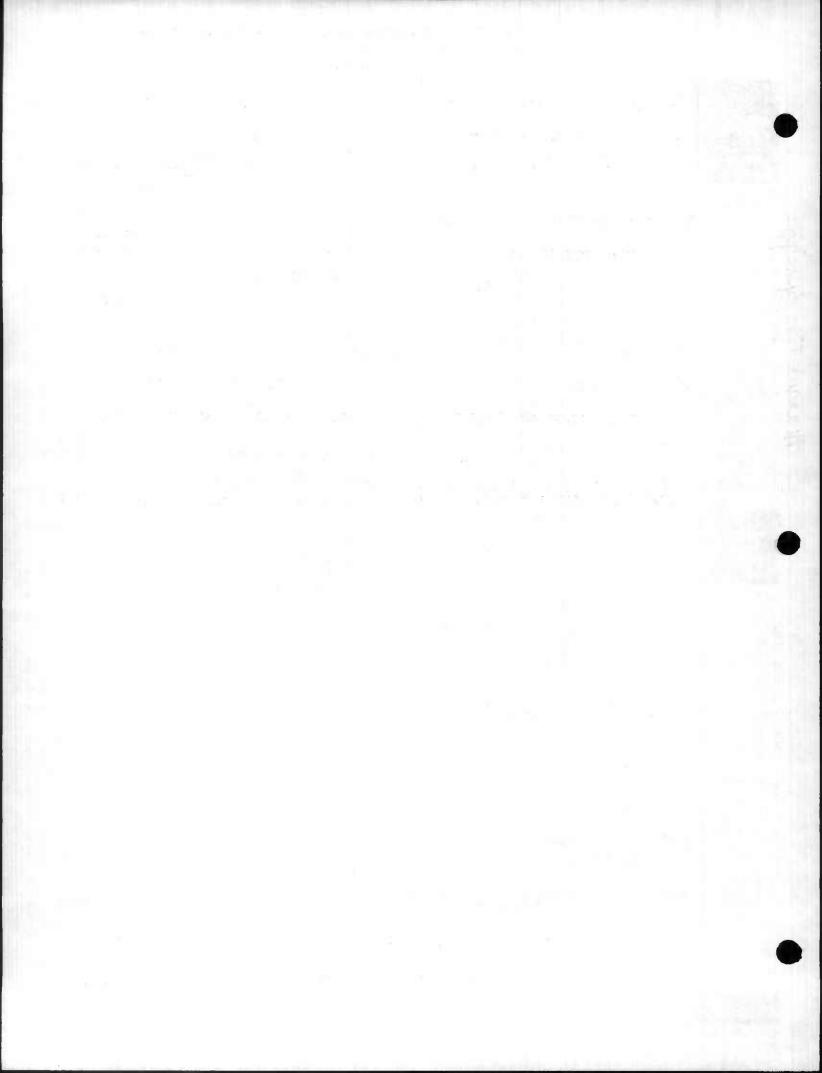
20602

State Registrar

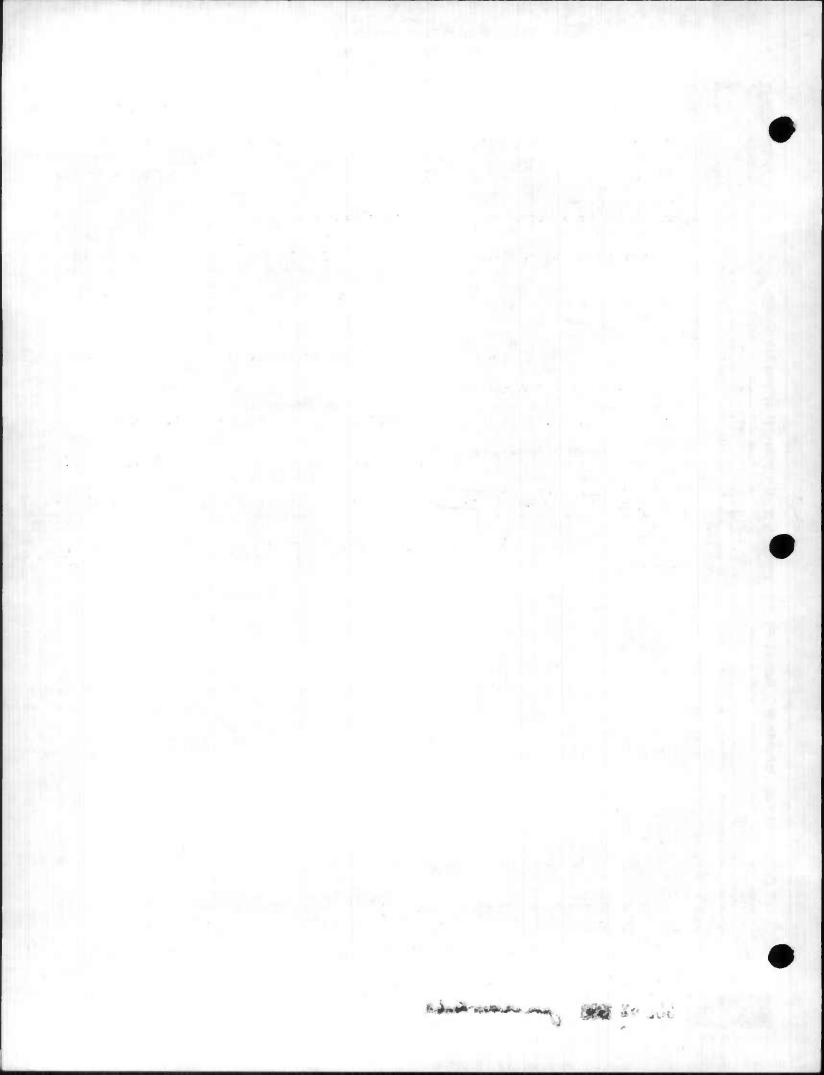
JUL 0 6 1998 > Julia dhudean Randell 31. Data filed (Month, Dey, Year)

Girija Rath, MD Cenna Medical Center 7C Post Office Road Waldorf, MD

30. Nama and addrass of person who completed causa of daath (item 23e) (Type, Print)

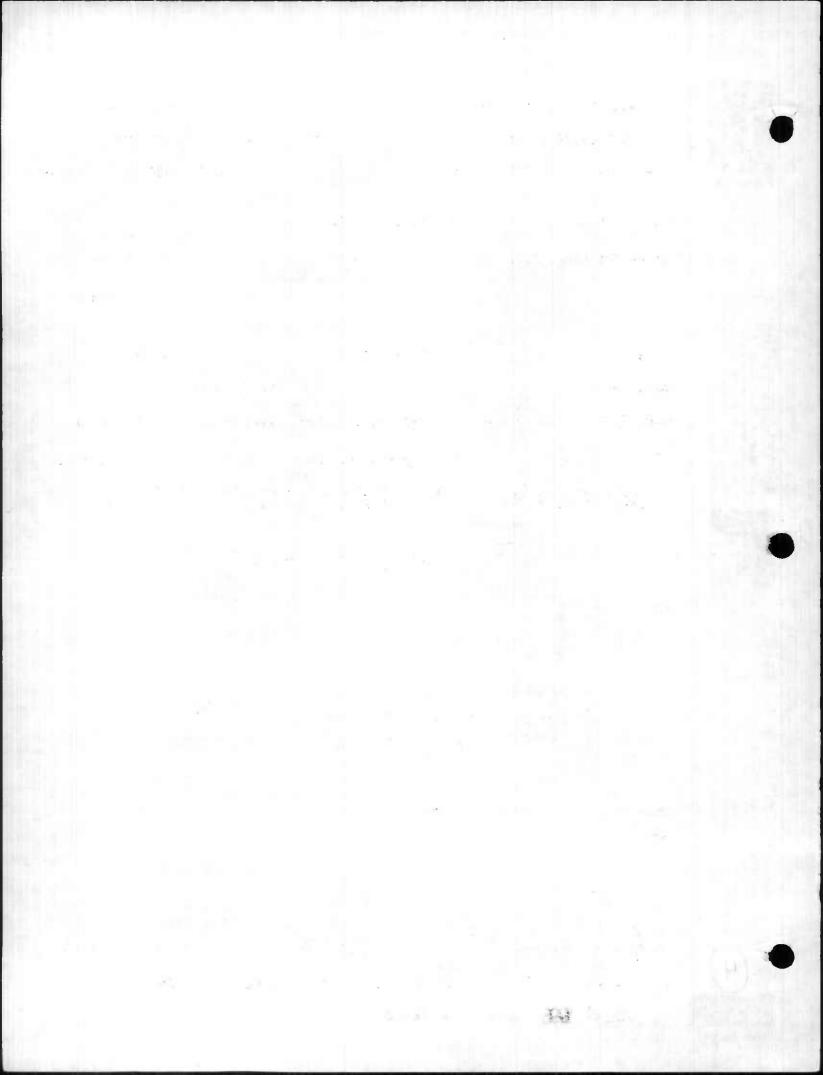


		State of Maryla		ertificate of			jiene leg. No. 98	21	790
	1. Decedent's Neme (First, Middle, La	st)		W. nen		2. Dete of Dee Month	th Dey	Year 3.	Time of Death
Physician /Medical Examiner	Faye Tolli 4e Facility Name (If not institution, give				4b. Clty, Town, or	June Location of Death		1998	10:15AM
Examiner	Prince George's				Cheverl	V	Princ	e Geor	0015
uneral	5. Sociei Security Number 6. 5		s. lest birthday) If Under 1 Year	If Under 24 Hrs	8. Date of Birth			(Stete or Foreign
rector	223-64-5899	OM 2QF	53 Yrs.	Months Deys	Hours Min	Nov. 2		Virgi	
	Usual Residence of Decedent								
Funeral Director	10e. Stete 10b. County		City, Town or I						Inside City Limits
5	Maryland Prince G	eorge's	Mit	chellvill	.e				1 No Yes 2 No
Director	10e. Street end Number			10f. Zip Code			10g. Citizen of W	Thet Country?	
	1603 Pebble Be				.0721			ed Stat	
by Funeral	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:	U,S. 13	. Was Deceden of If Yes, specify Cub		Specify Yes or No- rto Rican, etc.)	Specify	e - Americen II k, White, etc. Blac	
	15. Decedent's E		16a. Dec	edent's Usuel Occu	pation	at day	16b. Kind of Bu	siness/Industr	ry
Completed	(Specify only highest gra Elementery/Secondary (0-12)	College (1-4or 5+)	life.	re kind of work done DO NOT use retire	aduring most of wo ad)	orking			
E	Elomonioly/ observatly (o' 12)	4		Comput	er Speci	alist	Gov	ernmer	nt
Be (17. Fether'e Neme (First, Middle, Last				18. Mother's Ne	me (First, Middle,	Meiden Sumem	e)	
2	James Garfiel	d Barge, Sr.				Thelma V	Vilkins		
	19e. Informent's Neme/Reletionship (**		iling Address (Stree				State, Zip Coo	de)
	Celestine B. Bai			705 Anwel	1 Dr., R	ichmond,			
	20e. Method of Disposition		. Plece of Disp cemetery, cr	position (Neme of remetory or other pla	ece)	Date	20c. Location -	City or Town,	Stele
	4 Donetion 5 Other (Special		Mt. O	livet Cem	netery	7/3/98	Washing	gton, I).C.
	21. Signeture of Funerel Service Lice	nsee		22. Name end Addr	ess of Fecility	Stewart	Funeral	Home	
	Dan T	111 Jacob V 111		4001 Be	nning Rd	., N.E.			0019
	23a. Peut Enter the disease, or com	plications that caused the de	eth. Do not e	nter the mode of dy	ing, such es cerdie	ec or respiretory er	rest,	Ap	proximete
	shock or heart fellure. List only	one ceuse on each line.	1 1	0	1/	7			ervel Between set end Death
al	Immediate Cause (Final	Motos	Lax'c	Bree	ast (ance,	/	15	ulave
	diseese or condition resulting in death)	e. Due to	(or es e cons		-00 9	y		10	July 3
ě		200 (0	(01 03 0 0013	oquatios oi).					0
Examiner	Sequentially list conditions,	b. Due to	(or es e cons	equence of):					
	if eny, leeding to Immediate cause. Enter Underlying								
Cal	Ceuse (Diseese or Injury that initiated events resulting in death) Lest	c. Due to	(or es e conse	equence of):					
Jed	resulting in death) Lest								
Z'e		d		-					
Physician/Medical	Pert fl. Other significant conditions of	ontributing to death but not r	esulting In the	underlying cause g	iven In Pert I.	23b. Dld 1	obacco uae cor	ntributa to the	e ceuse of death?
hy						10	708 2 NO	3 Probabi	ly 4 Unknown
by						-			
8						24e. Wes	en eutopsy rmed?	eveilel	autopsy findings ble prior to
plet								of dee	etion of cause th?
Completed						101	res 20 No	1 🗆 Ye	es 28 No
Be C	25. Wes case referred to medical				26. Place of D	eeth (Check only o			
0	exeminer? 1 ☐ Yes 21 No	Hospitel: 1 Inpatient 2	☐ ER/Outpati	eni 3 DOA	ther	Home 5 ☐ Resid		er (Specity)	
H:	27. Menner of Deeth	28e. Dete of Injury	28b. Time	of 28c. Inju		-	now injury occur		
atio	1 Neturel 5 ☐ Pending investigation	(Month, Dey Year,	Injury		ork?]Yes 2 □ No		1		
Certification:	3 ☐ Sulcide 6 ☐ Could not b	Zoe. Piece of Injuly - A	t home, ferm,	street, fectory, office		28f. Location (S	Street end Numb	per or Rurel Ro	oute Number,
ert	4 Homicide	building, efc. (Spe	ocity)			City or Tov	ni, State)		
edical C	29a. Certifier 1 Certifying Pr (Check only 2 Medicaf Examone)	nysician: To the best of my k ninar: On the besis of exam- end menner steted.	nowledge, dec inetion end/or	eth occurred at the t investigation, in my	time, dete end plea opinion, deeth occ	ce, end due to the curred et the time,	ceuse(s) and ma dete end plece,	anner as state and due to the	d. e ceuse(s)
×	29b. Signature and title of certifier	#		29c. Licer	nse number		29d. Date signe	d (Month, De)	r, Year)
1	10/1	In Ba	11.5	DA	1878		Tuna	19	1999
	"Mun (- will	77(1)	. Dalas)	1020		JUNIE	, 40,	(110
-	30. Name and address of person who	completed ceuse of deeth ()	tem 23e) (Typ	e, Print)		Codor	D. (-	Can L	of un
	31, Date filed (Month Day, Year)	22 Basistrode St	/S L5	Green	1 way	Carter	DV. S	Y COUD	
State	31, Date filed (Month, Day, Year)	32. Registrar's Sic							



				State o	f Marylar		artmen ertificat			and M	lental Hy	ygiene Reg. No.		Fra.	
Physic		Decedent's Name (First, A GLADYS	Aiddle, La	THORN'	TON						2. Date of D Month June	Day 26		Year 998	3. Time of Death 8:40 AM
/Medi Exami		4a Fecility Neme (If not Insti									ocation of Dea		County		
		HOLY CR. 5. Sociel Security Number	-	HOSPITA	L 7. Age (In yrs.	last hirthday) If Under	1	SILVER If Under:					OMER'	
Funeral Director		578-60-8771		1 □ M 2√2 F	61	Yrs.	Months	Deys	Hours	Min.	8. Dete of B (Month, D Sept 8	ay, Year)	36	Sout	lace (Stete or Foreign try) h Carolina
2 -		Usual Residence of Deceder			100 0						-			Ta	
/anyle	ō	10a. Stete 10b. Co	unity			ty, Town or L		C						1	0d. Inside City Limits N☐ Yes 2☐ No
288-1	rect	N/A N/A 10e. Street and Number			was	hingto	10f. Zip					10g. Citi	izen of W	hat Coun	A
th with	ai D	2586 Naylor R	oad,	S.E. #	204		20	020				Uni	ted	State	es
5-0020 72 hours after death with the Manyland natural; or items 23s or 28s-1 show diest Examiner must be notified	by Funeral Director	11. Marital Status 1 Never Merried 2		Armed Fo	Ž∑ No ∕e	J,S. 13.			lispenic Orlean, Mexican Specify:		ecify Yes or N Rican, etc.)	10-		- America k, White, o	
15-00	ed b	3 XWidowed 4 ☐ Divo	rcea edent's E	Year or D	ates:	16a. Dece	edent's Usua	I Occur	ation			16b. KI	Ind of Bus	siness/Ind	
	Completed		ighest gr	ade completed) College (I-4or 5+)	(Give	e kind of wor DO NOT us	rk done	durina most	of work	ing				,
filed with Hygiene. other than	Con	12				Home	maker						vate		
tore, Maryland 212. ges 1 and 2 should be filed within to Health and Mental Hygiene. If item 27 is marked other than or other treumatic event, the Mental Hygiene.	Be	17. Father's Name (First, Mic Homer Gates	idle, Lasi	"							e (First, Middle BRov		Sumame	e)	
larylan 2 should be end Mental is marked o	T ₀	19a. Informent's Name/Rela	tlonship	(Type, Print)		19b. Mail	ling Address	(Street			el Route Num		or Town,	State, Zip	Code)
Mand 2 and 2 alth or 127 is pr trace		Rhonda T. Tho			hter	4910	Glas	smar	nor Dr	ive	, Oxon	H111	, Md	. 20	745
Baltimore, Normali. Pages 1 end. Department of Health Important: If item 27 any injury or other trease.		20a. Method of Disposition 1 X Burial 2 ☐ Cremai	ion 3 [Removal from		Place of Disp cametery, cre	osition (Nen	ne of ther ple	ce)		Date	20c. Lo	ocation -	City or To	wn, Stete
Page 1		4 □ Donation 5 □ Other	er (Speci	(y)	Har	mony M					7/2/98	Land	over	, Ma:	ryland
Baltim permit. Pa Departmen important: any injury		21. Signature of Funeral Ser 23a. Part1. Enter the diseas	By	as de		59 A	2617 P	DER enns	S. PO	PE I	FUNERAI	SE		0020	
Medical Examiner out of the bruel-transit the bruel-transit out of the	sal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	{	b	Due to (or as a conse	equence of):	FAI	lu	~				1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
death certific	by Physician/Medical	resulting in death) Last Part II. Other stgnificant cor	ditions	d	·	or es e conse		ause on	ven in Part I		23b. Die	d tobacco	Use con	tribute to	the cause of death?
P.O. hat the od by the detached	y Phys	End	S	9,0	chea	ا'د ا	John	to	e		×	Tyes 2	□ No	3 ☐ Prot	pably 4 Unknown
	Completed t		6	ellms	nut a	dire	re				24a. Wa per	is an autor formed?	psy	COI	are autopsy findings allable prior to mpletion of cause death?
C 2 5 6	Com										1□	Yes 2	No	10	Yes 2□ No
f Vital Roysleian: The last certificate he director, page	Be	25. Was case referred to me exeminer?	dical	Managhab.				100		of Deat	h (Check only	one)			
- 5 w 0	- T	27. Manner of Death				28b. Time		/A		-	me 5 Res				y)
ding th.: After	tlon	Natural 5 □ Pe	ending restigation		of tnjury th, Day Year)	Injury	M	8c. Injui Wo 1 🗆	rk? Yes 2 □				,		
Division If or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Co	ould not b	286. Place	of tnjury - At h	iome, farm, s	treet, factory	, office				(Street er own, Stete		er or Rura	I Route Number,
Division or with the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edicai			nystotan: To the miner: On the b and man			nvestigation	, In my c	opinion, dea			e, date and	d placa, a	and due to	the cause(s)
To To To con	×	29b. Signature and title of ce	A	the y	N		I	> 5	Se number	91		6 2	te signed		Day, Year)
(4)		30. Name and address of per Esteban Marc	quez	Md	210	l E Je		on S	St Roc	kvil	le Md	20849	9		
Sta Regist		31. Date filed (Month, Dey,) JUL 01	(ear)	_ / 4.	egistrar's Sign		ų								

DHMH 16 Rev 6/95



98-3669-033 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene UNKNOWN 98-138 Certificate of Death Reg. No. * GEORGE RAYMOND WILSON 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician GEORGE WILSON RAYMOND JUNE 26, 1998 9:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner D'ARCY & RITCHIE ROAD FORESTVILLE PRINCE GEORGES If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 1 M 2 □ F Hours 227-94-1007 40 Director FEB. 5, 1958 VIRGINIA Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow "natural", or items 23s or 28s-f show official Examiner must be notified at 1 □ Yes 2 □ No MARYLAND Directo PRINCE GEORGES' SUITLAND 10e, Street and Number 10f. Zip Code 10g. Citizen ot What Country? with 3339 HUNTLEY SQUARE DRIVE 20748 Funeral USA filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. 1 ☐ Yes 2 🔯 No if Yes, Give 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: AFRO AMERICAN by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiane. Elementery/Secondary (0-12) College (1-4or 5+) AUTOMOTIVE REPAIR MECHANIC 16. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental GEORGE WILSON BERTHA ASHTON 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748 19a. Intormant's Name/Relationship (Type, Print) Health a BERTHA WILSON--MOTHER item 2. 3339 HUNTLEY SOUARE DRIVE SUITLAND, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Burial 2 ☐ Cremetion 3 ☐ Removel from State = 8 Department of Important: If any Injury or Burial 2 Other (Specify) POTOMAC BAPTIST CHURCH HAGUE, VA et Signature of Funeral Service Opense 22. Name and Address of Fecility BERRY O. WADDY P.O. BOX 305 LANCASTER, VA 22503 fons that caused the gause on each line. eth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset and Death Part1. Enter the Physician Immediate Cause of disease or condition resulting in death /Medical Due to (or es a consequi) Examiner Examiner physician and s the burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last Due to (or as a consequence of): the death certificate be executed Box 68760. Physician/Medical Due to (or as a consequence ot): SB 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy tindings available prior to should t 24a. Was an autopsy performed? Completed completion of cause of death? The law certificata has page Division of Vital Attending Physicien: 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Stather (Specify) AT SCENE XXYes 2 No To this funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 26b. Time of to the 27. Manner of Death 28c. Injury et Work? Certification: After passingery vehicle to 1 Natural 2 Accident 5 Pending Investigation 2 No Found 6/24/98 0735 HRM 1 Yes death. n 24 hours after des ne Funeral Director nlately filled in by th 6 Could not be determined Street and Number or Hurain washing with State) DArcy Rood 4 3 ☐ Suicide 26e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28t 4 - Homlcide I'm was fine from the last of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

| Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ò 29e. Certifier edicai To the Hosp within 24 ho To the Fund completely f (Check only one)

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) HEUDORE M. KIN

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

JUNE 26, 1998

29c. License number

O.C.M.E

State Registrar

29b. Signature end title of certifier

31. Date tiled (Month, Day, Year)

JUL

02

32 Registrar's Signature

mo

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death **Physician** 9:45 AM ANTHONY L. WASHINGTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 1XXM 2□ F 578-96-4506 A 29 Vint. WASHINGTON, DC 1968 Director Usual Residence of Decedent 10c. City, Town or Location 10d. insida City Limits MARYLAND PRINCE GEORGES LANHAM 1XXVas 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8900 HICKORY HILL AVE. 20706 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 2 No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puero Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 8 1 ☐ Yes 2XXVo Specify: BLACK Specify: þ 3XXWidowed 4□Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN PRIVATE 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ed binout Mental marked CHARLES HOLBROOK ADA RANDALL 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nt of Health I If Item 27 is or other tra ADA RANDALL / MOTHER 8900 HICKORY HILL AVE., LANHAM, MARYLAND 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date FOREST HILLS MEM. CEM. 07-03-98 CLINTON, MARYLAND XX Burial 2 Cremation 3 Remove from State 4 Donates 5 Other (Specify) 5 Other (Specify) Funeral Service Licens Name and Address of Facility
DUDLEY FUNERAL HOME duars EDWARD M. 3200 RHODE ISLAND AVE., MT. RAINIER, MD DUDLE 20712 Interval Between Opset and Death Part1. Enter the disease, or complications that caused the desirt. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical mediate Cause (Final Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760 90 Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by I 1 Yes 2 No 3 Probably 4 Klinknown Division of Vital Records, þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 89 26. Place of Death (Check only one) 1□Yes 2D€0 Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 결 27. Manner of Death 28d. Describe how injury occurred 1. Ef Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 3 ☐ Suicide 6 ☐ Could not be 25e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Hamicide 24 hours a Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Cartifiar To the within 2 To the 29b. Signature and title of certain 29c. License number 26/98 18th (Nom 23a) (Type, Print) SARUIS Are Riverdale 31. Data filed (Month, Day, Year) State Registrar

were to move the way to be a fact of

ene	0	6	1	-1	0	1
g. No.	0	lin.		1)	

D.C. 20003

Approximate Interval Between Onset and Death

3. Time of Death

2:30 am

 Birthplace (State or Foreign Country) Wash., D.C.

> 10d. Inside City Limits Y□Yes 2□No

					Ce	rtificate of	f Death		Reg. No.	1	112
Physician	1. Decedent'a Name (aton				2. Dete of E Month 0.6	Death Day 2.0	Year 98	3. Time
_/Medical	4a Fecility Name (# no						4b. Cify, Town, or			nty of Deeth	
Examiner	Mariner				Mar	/land	Clinton		P.G		
Funeral Director	5. Social Security Num 579-32-8 Usual Residence of De	839	Sex 1 □ M 2 1 F	7. Age (In yrs. 76	last birthday Yrs.) If Under 1 Yea Months Day				9. Birth Cou Was	h . , E
72 hours effar death with the Maryland natural; or frems 23s or 25s-f show confined in the notified as	10a. State 1	0b. County		10c. City	y, Town or L	ocation					10d. Inside
28a-f sho notived at	D.C.	None		Was	hing	ton					X□ Ye
or 28a-f s be notified Director	10e. Street and Numb	er				10f. Zip Code			10g. Citizen	of What Co	untry?
234	1420 Mas	sachus	setts A	ve., S	E.	200	03		US	A	
alt, or items 23s traction and by Funeral	11. Maritel Status 1 Never Married 3 Widowed 4	2.6	Armed Fo	2 No	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (lban, Mexican, Pue o Specity:	Specify Yes or to to Ricen, etc.)		Rece - Amer Black, White ACK	rican Indian, o, etc.
aced E	18	5. Decedent's E		0.003.	16a. Deci	edent's Usual Occ	upation e during most of wo	orkina	16b. Kind o	f Business/I	ndustry
r than the Mon	Elementery/Second		College (1	-4or 5+)		DONOT use reti usewife		9	HOM	Ξ	
Tamerked other traumatic event, in	17. Father's Name (Fit Royal D		•				18. Mother's Na	ame (First, Midd rancis		neme)	
Heelth and N	19a. Informant's Name Thomas W			sband			et and Number or F				
P. P. P. P. P. P. P. P. P. P. P. P. P. P	20a. Method of Dispos 1 XBurial 2 0 4 Dopation 5	Cremation 3		State		osition (Neme of emetory or other p	tional	Date 6_30_9	20c. Location		
Department of Important: If any Injury or once.	21. Signature of Fune	ral Service Lice	ensee	elle	-	Ralph W	ress of Facility illiams h St.,	Funer S.E. W	al Ser	vice	
hysician	23a. Part1. Enter the shock, or heart f	disease, or con ailure. List onl	mplications thet c y one cause on e	eused the death ach line.	h. Do not e	nter the mode of d	ying, such es cardi	ac or respiratory	arreat,		Approxim Interval B Onset an
/Medical xaminer	Immediate Cause (Fir disease or condition resulting in death)	nal	a Sep	tic Sh	ock					7	
1			0			equence of):					
nine			Gas			inal bl	eeding				
al-transit	Sequentially list condi	itions, ediate	End		res e conse	equence of):	350			i	

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

stage renal disease

Due to (or es e consequence of):

metastasis to unknown orgin the brain for cancer of

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. left below the knee amputation history of hypertension

23b. Did tobacco was contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Wes an eutopsy performed?

24b. Were autopsy findings aveilable prior to completion of cause of death?

1 Yes 2 No 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

status post G-tube

25. Was cese referred to medical examiner?

6 Could not be determined

1 Yes 2 No

27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

1 (XNatural

2 Accident

4 Thomicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

29c. License number D25640

29d. Date aigned (Month, Day, Year)

06-24-98

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Khosrow Davachi, MD 1328 Southern Ave., S.E. Wash., DC 20032

State Registrar

31. Date filed (Month, Day, Year) JUL 01



Division of Vital Records, P.O. Box 68760

The law requires that the death certificate be

attanding physiciar for use es the bun

ed by the a

signed by t

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cartificata

Aftar this funeral

Jeral Director: A

completaly

To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this cardio

Physician/Medical

ģ

Completed

Be

To

Certification:

State of the sea of the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** 29, 1998 4c. County of Death Jessie Jones 6:10 AM Washington June /Medical 4b. City, Town, or Location of Deeth 4e Facility Nema (If not Institution, giva street and number) **Examiner** Manor Care Largo Prince George's Months Days Hours Mr. April 7, 1913 5. Sociel Security Number 7. Aga (In yrs. lest birthdey) Birthplaca (State or Foreign Country) **Funeral** 1□M 2√F 578-07-4877 85 Yrs. Director South Carolina Uauel Residence of Decadent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Bowie 1 X Yas 2 □ No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whef Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Meniel Hygiene.
Important: If item 27 is merked other than "natural", or items 23s or a part in I item 27 is merked other than "natural", or items 23s or posses with injury or other treumatic event, the Medical Exportant Para page. 4201 Glem Dale Road 20720 USA Funeral Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, Whita, efc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yas, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yea 2X No Specify: Specify: Black þ 3 □Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Private Seamstress 18. Mother'a Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middla, Lest) Julian Jones Dicie Gladden 19b. Meiling Address (Streat end Number or Rurel Route Number, City or Town, Steta, Zip Code) 19e. Informent'a Neme/Reletionship (Type, Print) J. Yvonne Brown/Daughter 4201 Glenn Dale Road, Bowie, Maryland 20720 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burlel 2 ☐ Cremetion 3 ☐ Removal from Steta 4 ☐ Donetion 5 ☐ Other (Specify) Ft. Lincoln Cemetery 7/2/98 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Facility J. B. Jenkins Funeral Home harles J Dowman 7474 Landover Road, Landover MD er the mode of dying, such as cardiac or respiratory errest, D 20785 Approximete Interval Between Onser end Deeth 23a. Part1/Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failura. List only ona cause of each line. **Physician** Immediete Ceuse (Finei disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): Examiner and d-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resuiting in death) Lest Due to (or es e consequence of): physician a s the buriat-t Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. thed hed 23b. Did tobacco use contribute to the cause of deeth? signed by 1 d be detact 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Inknown ž þ law requires Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to available prior to completion of cause of death? frector, page 2 s 257No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) DNO Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpetient 3 DOA ä 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After 1 Naturel
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Direc 4 Homicide Pours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(a) and manner as stated.
2 Medical Examiner: On the best of axamination and/or invasfigation, in my opinion, death occurred at the fime, date end piece, and due to the ceuse(s) end manner steted. 29a. Certifier Medical (Check only 8 To the To The To the P 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) My cause of deeth (Item 23e) (Type Print) 30 Name and address of person who completed SUU AMMARULIS 31. Dete filed (Month, Day, Year) JUN 3 0 1998 Registrar

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Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) 23 Day +. WILLIAMS 18667 JUNE 1922 4c. County of Death 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death TAKOMA PANK WASHINGTON ADVONTIGE HOSPITOL 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2\ F Months Days Hours Min Yrs. 55 March 29, 1943 Mexico 217-42-3014 Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 N Yas 2 No Maryland Prince George's Riverdale 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5320 Wiley Street 20737 U.S.A. 12. Was Decadent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) (unknown) Homemaker Own Home 18. Mothar's Name (First, Middle, Maidan Sumeme) 17. Fathar's Nama (First, Middla, Last) John Duffy Evelyn Ballard 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, informent's Name/Relationship (Type, Print) Lorraine E. Lowe - Cousin 773 Chopping Road, Mineral, Virginia 23117 20b. Place of Disposition (Neme of cemetery, cremetery or other pleca) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 Buriat 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 6/27/98 Alexandria, Virginia 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Gasch's Funeral Home Enry 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Parl1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Death SUFFOCATION (RESPIRATORY AGREST Immediete Cause (Final disease or condition resulting in death) BRIRATION OF FOOD BOWS Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequenca of): HEMILINGUECTOMY COMPRESSION FRACTURE/RT. PELVIC FRACTURE 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) 12 Yes 2 No Hospital: 1 ☐ inpatiant 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? Injury PEU AT HOME CINCUR SMUCT UNCURAL.
PATIENT OLD WIT DETAIL HOD

281. Location (Street end Number or Rurel Route Number,
City or Town, Stete) 1600 8 M

1 Yes 2 No

D15236 DME

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated.

29c. License number

5320 WILET ST, RI WURLE MO

29d. Date signed (Month, Dey, Year)

Just 23, 1998

Physician /Medical Examiner

the death certificate be executed

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 is marked other th any Injury or other traumatic event, the phose.

Physician

Examiner

Funeral

Director

r than "natural", or items 23s or the Medical Examiner must be a

the Maryland r 28a-f show

filed within 72 hours after death

Baltimore, Maryland 21215-0020

/Medical

Directo

Funeral

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Completed

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Examiner Physician/Medical funeral

physician ans the burial-to signed by the a d be detached f

P Completed Be 70

After after death. Director: Aft 2 24 hours after Funeral Dire letely filled in b Hospital

Certification: Medicai

To the h writin 24) to the Fund mpletely fill State Registrar

31. Date filed (Month, Dey, Year)

1 Natural

2 Accident 3 ☐ Suicide

4 ☐ Homleide

29a. Cerulin

29b. Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL I. MARGOUR, MO. 11/25 BOCKING PIKE, LOCKVING, MO 20852

32. Registrar's Signatura

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

and title of certifier

5 Pending

invastigation

6 Could not be determined

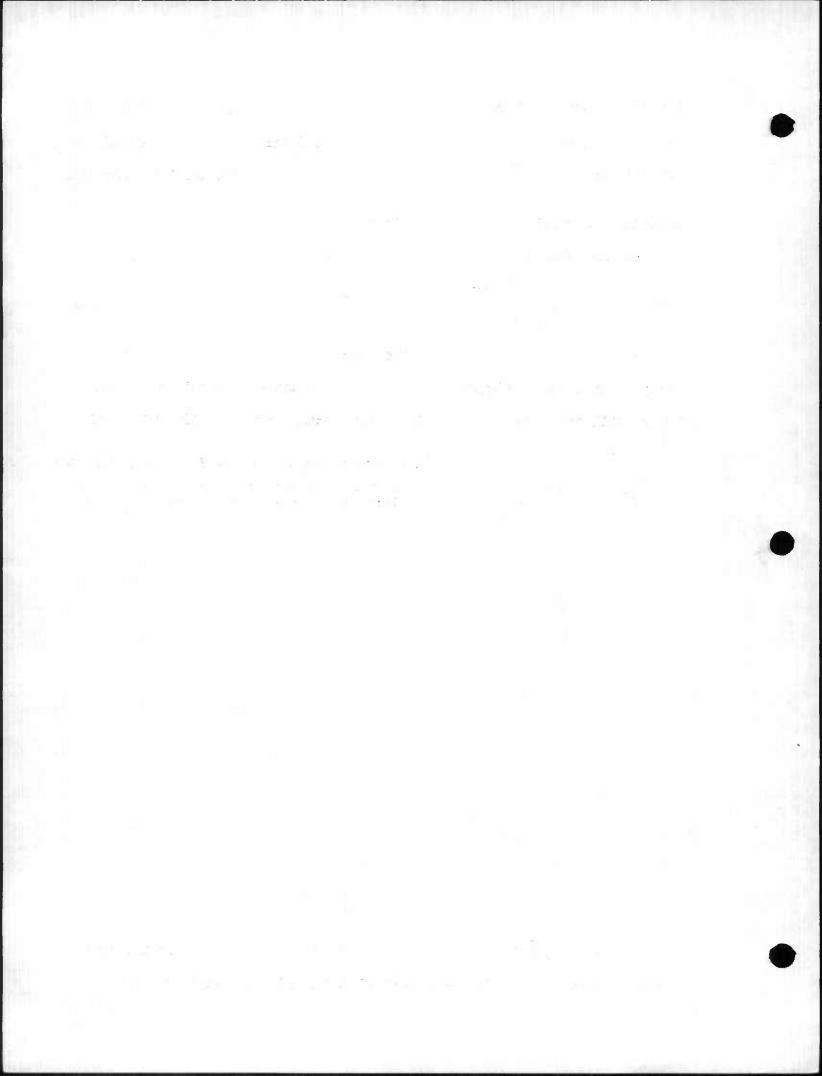


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			Webb Hall Manor					Bel Ai			rford		
	Funeral Director		5. Social Security Number 6. Sec. 220-09-5788	9X 7. Ag □M 2√ F	e (In yrs. lest b 79	Yrs. If Un Month	dar 1 Yaar ns Deys	If Under 24 Hours	Min. (Month,	Birth Day, Yeer) 16, 1918	9. Birthi Cour Mar	olece (Stete ntry) yland	or Foreign
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	· ·		Alfred D. Sparks,				L Roa	d, Bel	Air, Mar	yland 2	21014		
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State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death

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	Funeral Director		5. 2
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28a-1 show any injury or other traumatic event, the Medical Examine must be notified at pince.	To Be Completed by Funeral Director	10 Ma 10 11 11 11 11 11 11 11 11 11 11 11 11

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Physician Hileania Examiner

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Funeral Director: A pletaly filled in by tha fu

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Certification:

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The law requires that the death certificate be asscuted

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Diseese or Injury that initiated avants rasulting in daath) Last

Immediata Cause (Final disaasa or condition rasulting In daath)

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21. Signatura of Funaral Sarvice Licansaa

Cardiouscular diseex Dua to (or as a consequence of)

Myers Church Cemetery July 2,1998

22. Nama and Addrass of Facility

Dua to (or as a consequence of)

Adams Funeral Home Aquasco, Maryland 20608

Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death?

2 No

JUNE

Upper Marlboro,

Approximata Interval Batween Onsat and Death

24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

27,1998

1 PYas 2□ No

1 Yee 2 No 3 Probably 4 Unknown

1 Yas 26. Placa of Daath (Check only ona)

Part 1. Enter the disease, or complestions that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. Lest only one cause on each line.

25. Was cesa rafarred to madical axaminar?
1 X Yas 2 No Othar: 4 Nursing Home 5 Residence 8 Othar (Specify) 3EXDOA 1 Inpatiant 2 ER/Outpatient 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred

1 Naturel 5 Panding Invastigation 1 Yas 2 No 2 Accidant 6 Could not ba datermined 28e. Plece of Injury - At homa, ferm, straet, factory, office building, etc. (Specify) 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide

29a. Certifiar

O.C.M.E

1 Cartifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the ceuse(s) end mannar as stated.

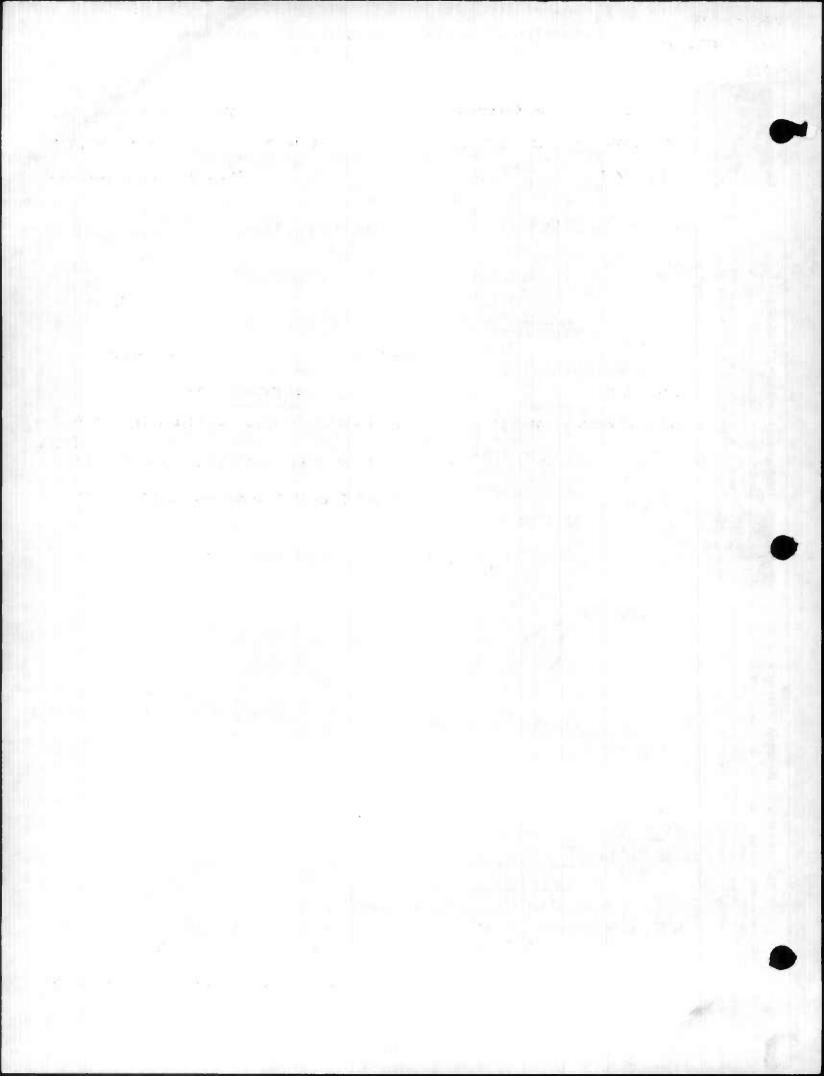
2 Medical Examiner: On the basis of axamirretion and/or investigation, in my opinion, deeth occurred at the time, data and place, and dua to the cause(s) and mannar stated. (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year)

Powler

30. Nama and addrass of parson who completed ceuse of death (Itam 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filad (Month, Day, Year) 32. Registrar Signetura JUL Julia Davidson Rendall 1998 0



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 24, 1998 Margaret Young June 11:04 a.m. 4c. County of Death 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) ashington NOSPITAL If Under 1 Year Hoventist IAKOMA tark IONTGOMERY If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 2-2-7. Age (In yrs. last birthday) 5. Sociel Security Number 6. Sex Deys 7.30.4996 1 M 2 F Richmond Co. VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limita 1 Yes 2 □ No 75V 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code NUE Was Decedent Ever in U.S. Armed Forces? 14. Raca - American Indien Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1□ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent'a Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) aNAGER 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) 19a. Informent's Name/Relationship (Type, tsville ML eynola OX 20b. Place of Disposition cemetery, cremetory Date 20c. Location - City or Town, Stete 20e. Method of Disposition Burial 2 Cremetion 3 Removel from Stete 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funerel Service Licanse Inc. NE., Wash. D 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting In death) Unknown Greater than oncestive Greater than Cordiomy Due to (or as e consequença of) Greater than two years 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Hyperthy roidism 24b. Were autopsy findings evallable prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

attending physician and for use as the burial-transit

signed by the a

After this certificate hes I

Director:

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Completed

Be

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Medical Certification:

The law requires that the death certificete be executed

P.O. Box 68760,

Division of Vital Records.

Physician:

Hospital or Attending

death.

To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

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Completed

Be

Funeral

Director

r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at

deeth with the Marylend

filed within 72 hours after

Pages 1 end 2 should be

al Hygiene.

end Mental

permit. Pages 1 end 2 sh Department of Health end Important: If Item 27 is m any injury or other traum once.

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vilux ler heart Cerebrovascular

1 Yes 20 No 1 ☐ Yes 2 ☐ No

25. Was case referred to medicel 1 Yes 2 No

Hospital: 5 Pending investigation

6 Could not be determined

28e. Date of Injury (Month, Dey Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Plece of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

27. Menner of Deeth

1, Maturel

2 Accident

3 Suicide

4 Homicide

t⊠ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the ceuse(s) end manner as stated.

2 ■ Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

CARIOLOGIST

29c. License number

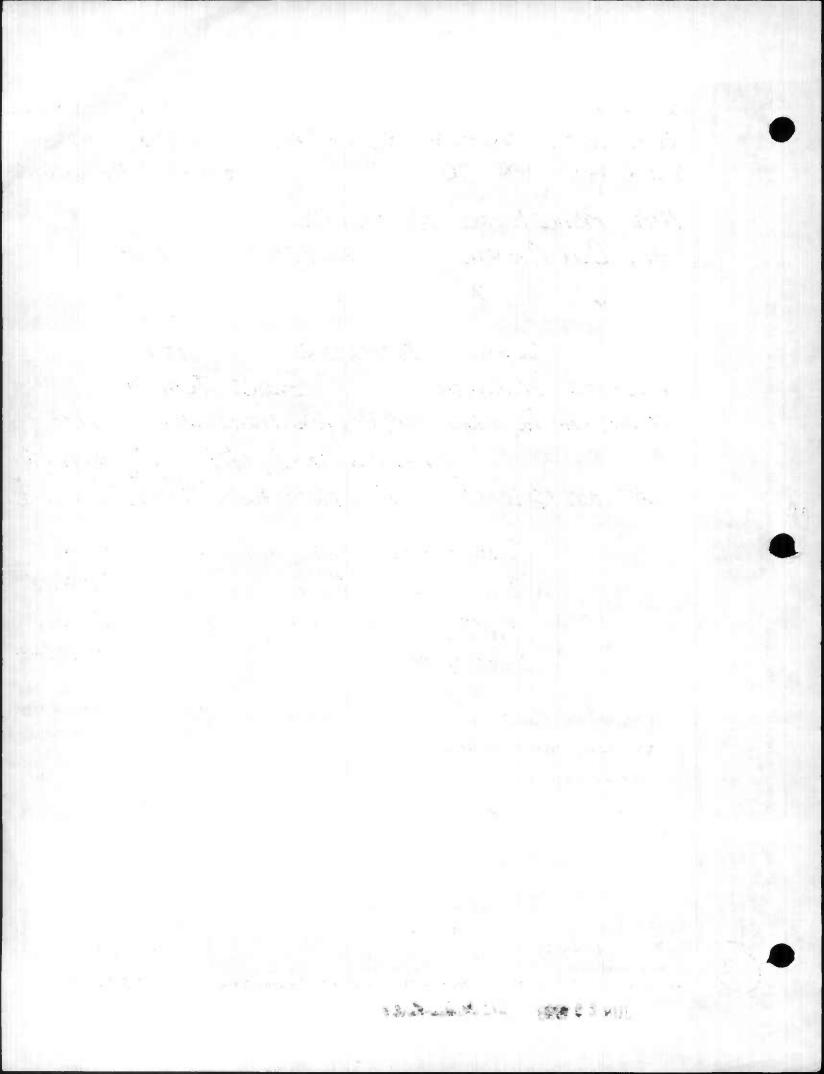
29d. Date signed (Month, Day, Year)

30. Neme and eddress of person who completed sause of death (Item 23e) (Type, Print)

Laurence R. Kelley, M.D., 7600 Carroll Avenue, Takoma Park, Maryland 20912 31. Date tiled (Month, Day, Year)

State Registra

32 Registrar's Signeture



23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evalleble prior to completion of cause of death? 1 Pres 2 No

Approximate interval Between Onset and Dea.

3. Time of Death

23:51 PM

Birthplace (State or Foreign Country)

Wash., D.C.

10d. Inside City Limits

1 Nes 2 No

1 Tes 2 No

24e. Wes an autopsy performed?

29d. Date signed (Month, Day, Year)

25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2□ No

Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of

1 ☐ Yes 2 ☐ No

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29b. Signeture end title of certifier hup, no

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

JULY 05, 1998 OCME

30 Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

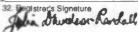
Registrar

JUL 0 9 1998

5 Pending

investigetion

6 Could not be determined



24 hours e

To the F within 2

completely

Box 68760 Division of Vital Records.

2 hes

3 certificete funeral director,

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Completed

Be

To

Certification:

Medical

27. Menner of Deeth

1 Naturel

2 Accident

4 | Homicide

(Check only one)

31. Dete filed (Month, Dey, Year)

3 Suicide

29e. Certifier

this Affer

or Attending Physician: ofter deeth. Director: Af

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 8, 12:5074 Harry Atwell 1998 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Baltimore City
If Under 24 Hrs. 8. Deta of
S Hours Min. (Month 6503 Detroit Avenue If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stata or Foreign Country) 8. Deta of Birth (Month, Dev. Year) Days 1√2 M 2□ F Months Yrs. 212-12-0915 78 Feb. 26, 1920 Balto., Md. Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 N Yes 2 No Md. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6503 Detroit Avenue 21222 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Tyes 2 No If Yes, Give 7/20/45— Year or Dates 1/15/47 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) Elamantary/Secondary (0-12) College (1-4or 5+) 12 Freight Company Mechanic 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Harry M. Atwell Viola M. Waldman 19b. Malling Addrass (Street end Number or Rurel Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Dawn L. Emmons/Step Daugh. 5 5th Avenue, Brooklyn Park, Md. 21225 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 7-10-1998 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore-Washington Crematory Laurel, Md. 22. Name and Address of Facility Bradley-Ashton-Dabrowski-Matthews Funeral Home 2134 Willow Spring Road, Baltimore, Md.

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

April 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

April 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

April 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

April 23a. Part1. Enter the disease, or complications that caused the death. 21222 Approximate Interval Between Onsef and Death ACUTE CONGESTIVE HEART FAILURE Immediate Ceuse (Final disease or condition resulting In death) Due to (or as a consaquence of): YEARS CORONARY DISEASE ARTERY Due to (or as a consequenca of): Due to (or as e consequence of): 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case refarred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumatic event,

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

r than "natural", or itsme 23a or the Medical Examiner must be a

Director

Funeral

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Completed

Be

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.

confincate

after death Director:

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Exami Sequentially list conditions, if any, laading to immadiata cause. Enfer Underlying Cause (Disease or Injury edical that initiated events resulting in death) Last Physician/M

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Completed

Be

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edical

1 Yes 2 No 27. Manner of Death 1 Netural

5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homleide

28a. Date of Injury (Month, Dey Year)

Place of Injury - At home, ferm, streef, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

29c. License number

1 Yes 2 No

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29a. Certifier (Check only one) 29b. Signeture and title of certifier

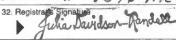
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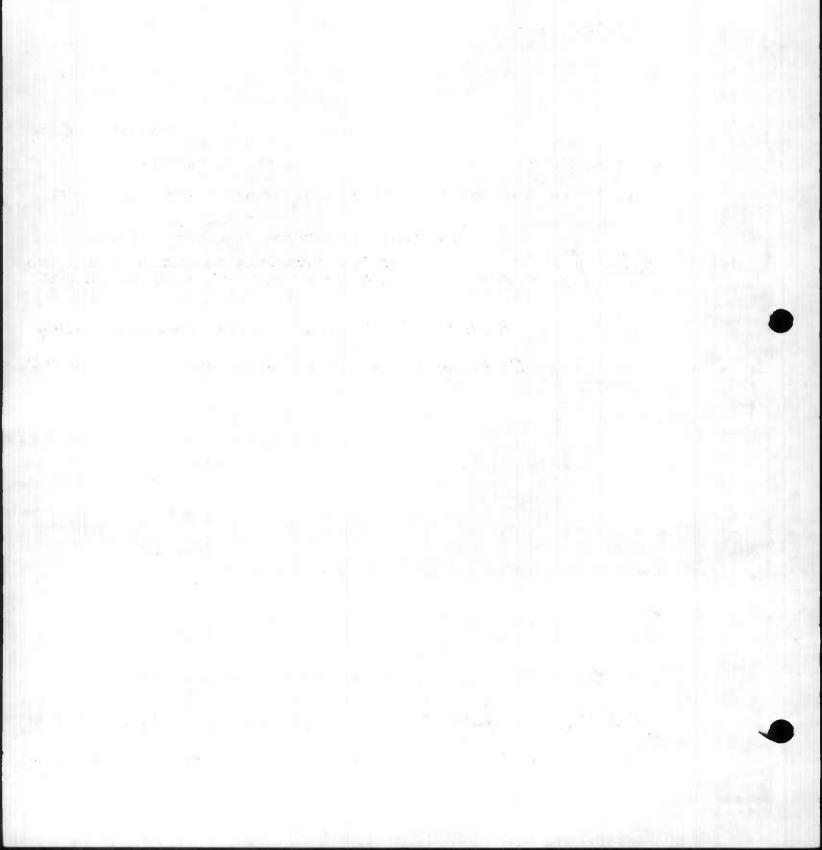
29d. Date signed (Month, Day, Year)

30. Nema and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

JR MORA 1576 MERRITT BLUD. BALTO, MD 21222 BC. VENERACION 31. Date filed (Month, Dey, Year)

Registrar



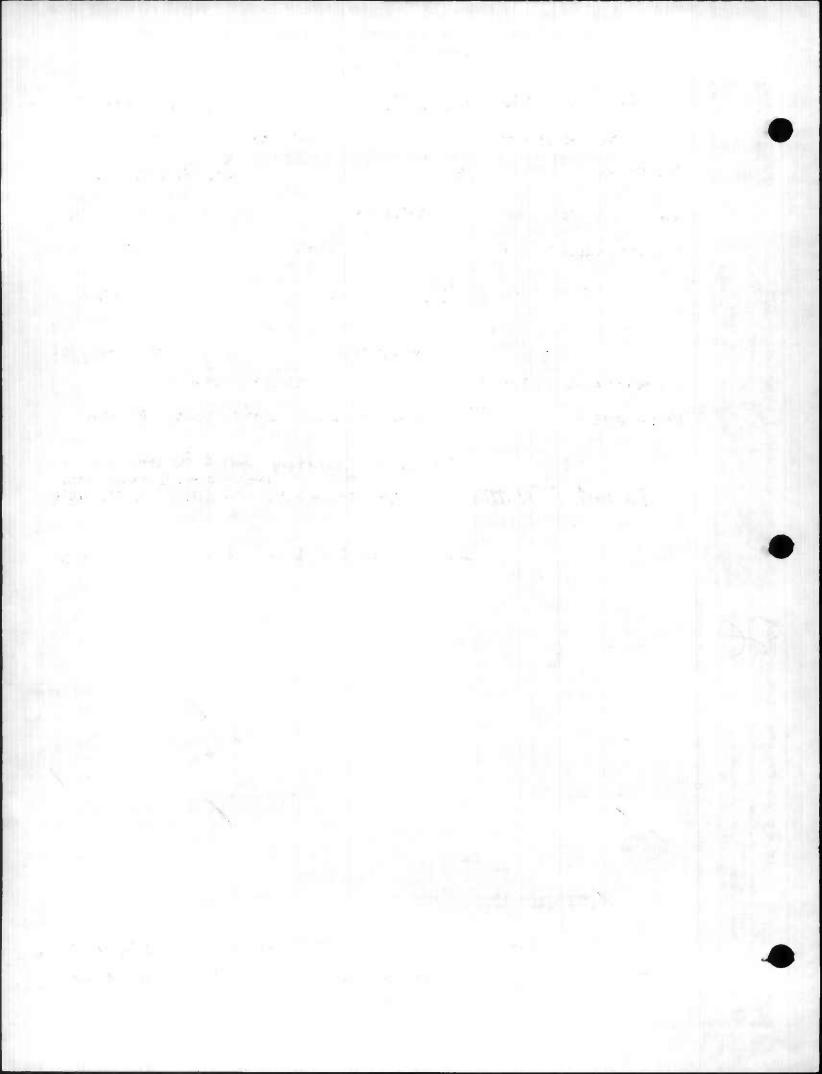


Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) J Month Bailey **Physician** Alvin trederick 2200 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a Baltimore 4409 Springdale Avenue If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** tom 2□ F Days Hours Min 66 Yrs. 212-30-5938 Director Jan. 16, 1932 Usual Residence of Decedent with the Manyland permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or itema 23s or 28a-f show any highry or other traumetic avent, the Wedical Example must be notified at page. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Md. n/a ★X Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 4409 Springdale Avenue USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1051 Was Decedent of Hispenic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 D Yes 2 No 1951 If Yes, Give Year or Dates: 1953 1 Never Married 2 Married altimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 ☑ Xo Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) State of Maryland Administrator 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Mildred Johnson Frederick Alvin Bailey SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4409 Springdale Avenue Baltimore, Md. 21207 19a. Informant's Name/Relationship (Type, Print) Wife Vivian Bailev 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burlal 2 Cremation 3 Removal from State Wikes Cemetery July 18 Reisterstown, mo. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Servica Licenses Herbert 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Finat disease or condition resulting in death) /iviedical Cell Jew **Examiner** Due to (or es e consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of) Division of Vital Records, P.O. Box 23b. Did tobacco use contributa to the cause of death? Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? Completed completion of cause of death? page 2 s 2 No 1 ☐ Yes 2 No 1 TYes or Attending Physician: director, 25. Was case referred to medical examiner? 28. Place of Death (Check only one) To Other: 4 Nursing Home 1 Yes 3 No Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28d Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier edical completely (Check only To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number a 170854 July 15, 199% 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 1041 Bultmare, Md St Pad Pl Risebers 4027 301 A 32 ASTAVASIONUM RONDAM

DHMH 16 Rev 6/95

Registrar

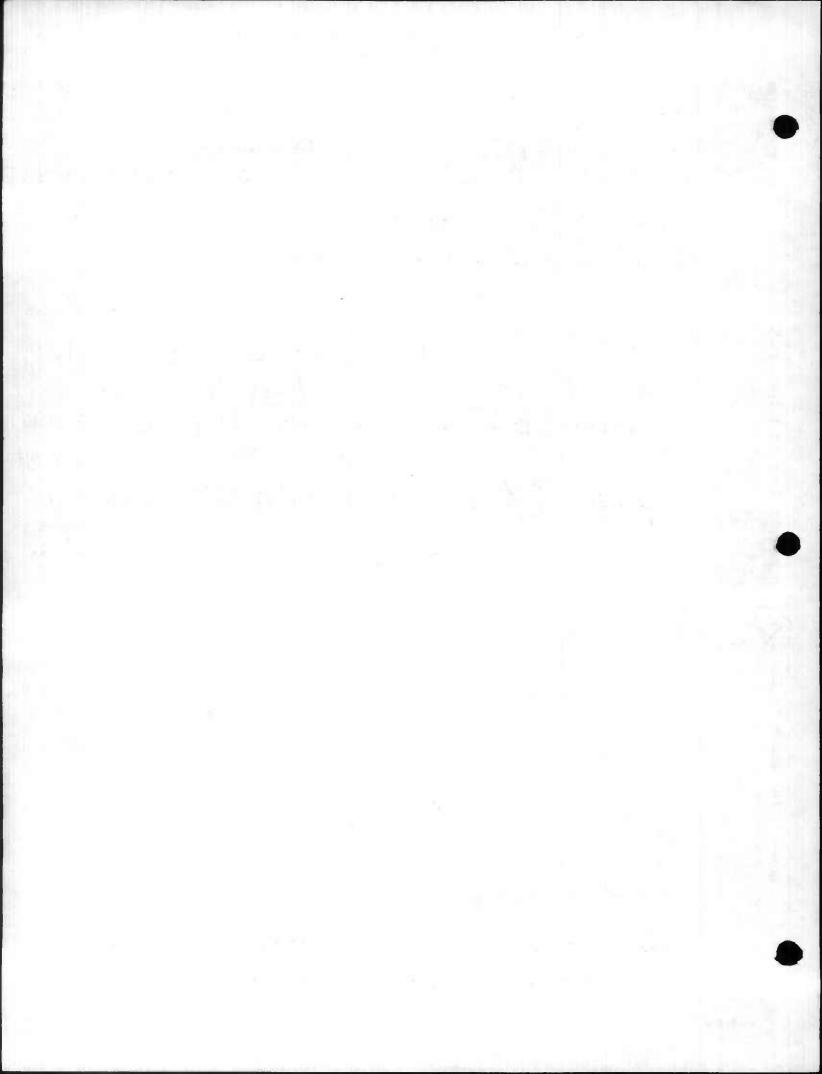


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Fundar 24 Hrs. 8. Data of Bir If Undar 1 Yaar 8. Data of Birth 9. Birthplece (State or Foreign 5. Social Security Number 6. Sax (In yrs. last birthday) **Funeral** 217-34-6843 Days 1□ M 2× F Hours Yrs. Director Usuel Rasidance of Decedant the Maryland 10e. State 10b. County 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiens. Important: If them 27 is an articled other than "natural; or items 23a or 28a-f ahow any Injury or other traumatic event, the Marical Examines must be notified as 1 Nas 2 No by Funeral Director laryland mar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 50 e Race - American Indian, Bleck, Whita, atc. Was Decedent Ever In U.S. Armed Forces? Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Merital Status 12. 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Datas: 1 Nevar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Blac 3 DWidowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 17. Fathar's Nama (First, Middla, Last) 's Nama (First, Middla, Maidan Surnama) Be 2 710 n's Name/Ralationship (Type, Print) (daughter) 19b. Mailing Addrass (Street and Number or Flural Town, Stata, Zip Coda) 20b. Pleca of Disposition (Nama of complany, cramatory, or other place) S rall 16 20a. Mathod of Disposition 20c. Location - City or Town, Stata 15 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Addrass of Facility North Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or heart dilure. List only one cause on each line. Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical 9 month Cancer **Examiner** Dua to (or as a consequence of): Physician/Medical Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants resulting in daath) Lest Dua to (or as a consequance of): P.O. Box 68780, Dua to (or as a consequence of): The law requires that the death certif Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 Unknown Division of Vital Records. à 24b. Wara eutopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? pege 2 should Be Completed certificate has 1 Yes 1 Tyas 2 No or Attending Physician: filled in by the funeral director, 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) 1 Yas 2 No Hospital: Other: 4 Nursing Homa Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 5 Rasidance 6 Other (Specify) Aftar this 28c. fnjury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Year) Natural 5 Panding Invastigation 1 Yas 2 No death. 2 Accidant within 24 hours after deat To the Funeral Director: 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 6 Could not ba datamined 3 Suicida 28a. Placa of Injury - Af homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida To the Hospital Certifying Phyefclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Phyefclan: To the best of my knowledge, death occurred at the time, due to the cause(s) and manner as stated.

| Medical Examinar: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar completaly (Check only one) 29b. Signature end titla of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 40854 30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print) 301 St Paul Pl Buldiner NO 31. Data filed (Mon 1 Pay, 1'66) 1998 32. Rodera's Manue Rendale State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death 8:15 Am Month BENSON ulu 4a. Facility Name If not institution, give street and number) 4b. City, Town, or Location of De-4c. County of Death Liberty Medical Center Baltimore n/a if Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1□ M 2√5 239-07-7468 76 Yrs NC. Nov. 9, 1921 Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore XXYes 2 No 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 1644 N. Warwick Avenue 21216 USA 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Biack, White, etc. 13. Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritai Status 1 ☐ Yes XX No If Yas, Giva Year or Dates: 1XX ever Married 2□ Married 1 ☐ Yas 2 ☑ to Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 10th Grade Factory Worker Canning Company 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Wiley Martin Mittie Benson 19a. Informant's Name/Reletionship (Type, Print) sister-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mattie Benson 1644 N. Warwick Avenue Baltimore, Md. 21216 in-law 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State SBurial 2 Cremation 3 Removal from State Voshell Cemetery July 16 Dundalk, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 leen 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each lina. Onsat and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): ASDITOSTICA Acute respiratory 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown IN Fector 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? complation of causa of death? 28. Place of Death (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28b. Tima of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Md.

Director

Funerai

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Completed

Funeral

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rel', or items 23e or 28a-f shov Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "neturel", or items 23e and highry or other treumatic event, the Medical Examines must once.

Baltimore, Maryland 21215-0020

Records. P.O.

Division of Vital or Attending Physician: Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

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Completed

Be

Certification: To

page 2 certificate

funeral

filled in by

completely

After

24 hours after death. Funeral Director: A

To the Within 2

Hospital

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes

30. Name and address of person who completed cause of death (Ilem 23e) (Type, Print

LAMB

Natural

Accident

4 Homicide

3 ☐ Suicide

5 ☐ Pending 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Tyes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) end menner stated.

29b. Signatura and title of cartifiar

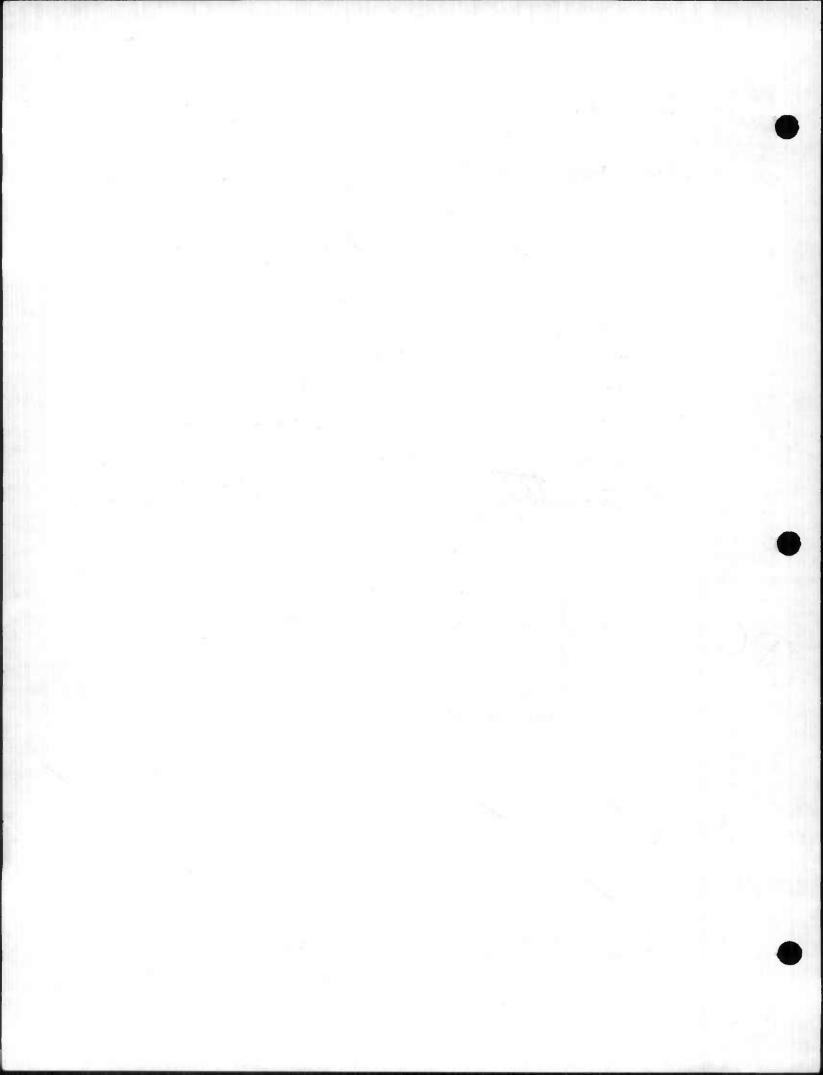
29c. License number

29d. Date signed (Month, Day, Yaar)

PRONCE 31. Date filed (Month, Day, Year)

Registrar's Signature

State Registrar

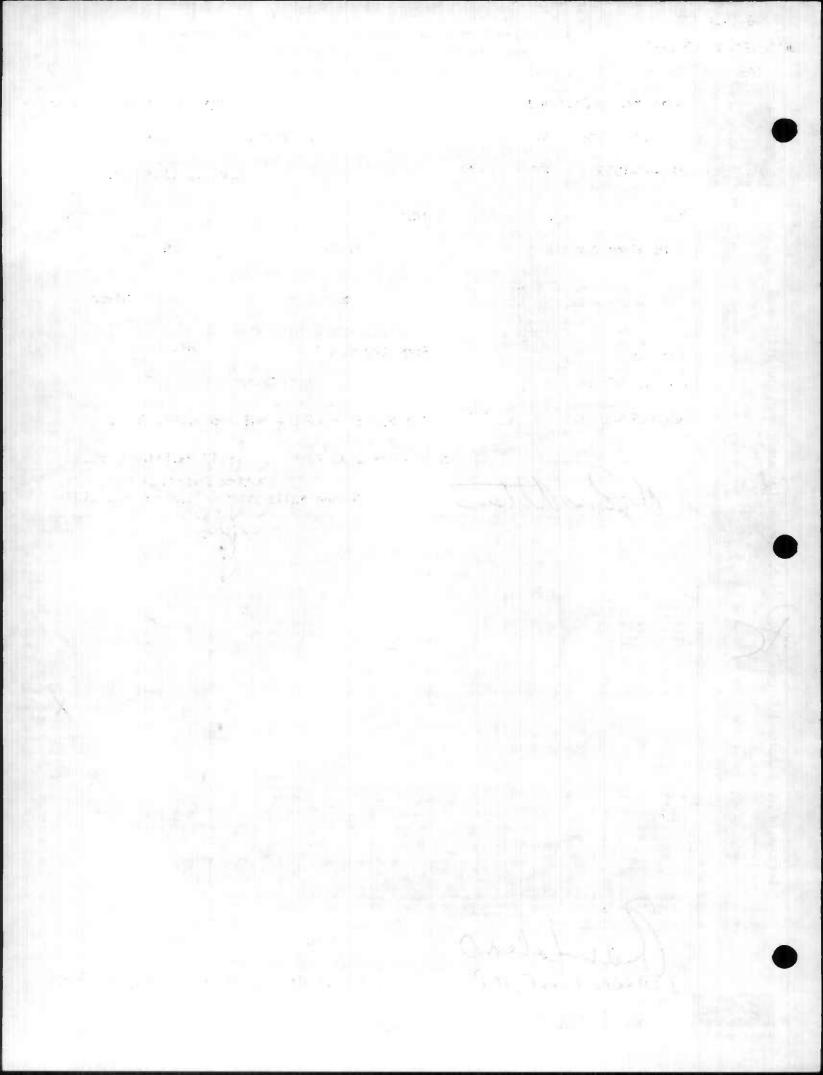


JOE WESLY CALDWELL State of Manyland / Department of Health and Mental Hygiene

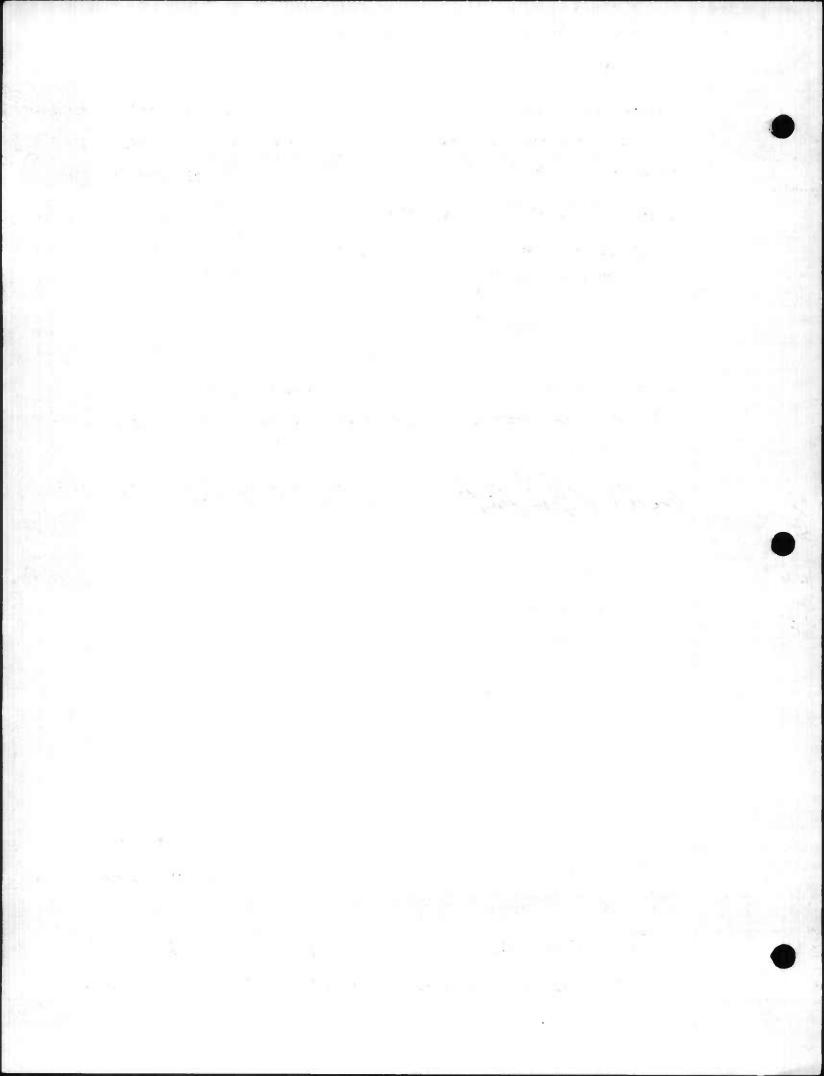
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ineral ector		elai Security Num -68-195		ax M 2□ F	7. Aga (In yn	s. last birthda Yrs.	y) If Under 1 Months	Yaar Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Nov. 3	th ay, Year,	958	9. Birthplac Country) NJ •	e (State or Foreign
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State Registrar

32. Registrar's Signatura



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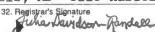
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth John William Diehl, Jr. Month Dev **Physician** July 13, 1998 4:30 PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) Examiner Genesis Eldercare Franklin Woods Rossville Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) If Under 1 Year 5. Sociel Security Number 6. Sex ★D M 2□ F 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Days Months 219-26-8739 61 Yrs. Director Jan. 17,1937 Maryland Usual Residence of Decedent with the Manyland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 7516 Carroll Avenue 21222 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DXYes 2 DNo If Yes, Give Year or Dates: Viets Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian. 11. Meritel Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or the 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify þ Vietnam 3 ☐ Widowed 4 🕅 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Repairman Telephone Company 12 Years 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Bertha Elaine Weinreich John William Diehl, Sr. 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. tnforment's Name/Reletionship (Type, Print) Dundalk, Maryland 21222 203 Maple Ave. Mr. Dale D. Dieh1/Son other 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removal from State injury or Hilltop Service Corp. 7/17/1998 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name end Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. Iny chrisi 7922 Wise Ave. Dundalk, Maryland 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, and or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical tmmediate Cause (Final disease or condition resulting in deeth) **Examiner** Examiner Sequentially iist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) emi c Physician/Medicai thet Initiated events resulting In deeth) Lest Due to (or es a consequence of) 85 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. Division of Vital Records, P.O. 2 No 3 Probably 4 Unknown bengis d be det by 24b. Were autopsy findings evailable prior to 24a. Wes en eutopsy Completed peed completion of cause of deeth? page 2 2. NO 1 Yes 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 9 funeral 28a. Date of Injury (Month, Dey Year) 28c. tnjury et Work? 27. Menner of Death 28d. Describe how injury occurred 28b. Time of Certification: Attending 5 ☐ Pending s after death. 2 No 1 Yes Investigetion 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 8 7.24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, dete end placa, and due to the ceuse(s) and menner es stated.

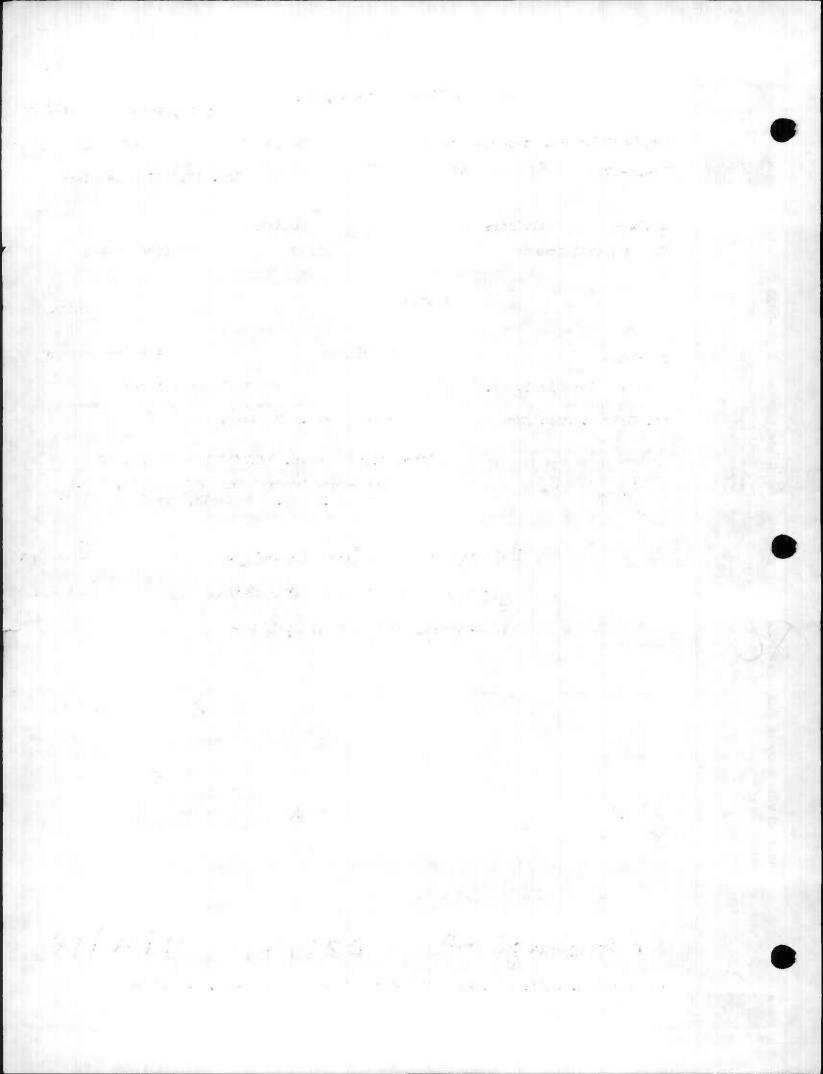
| Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end placa, and due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one) To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Panayiotis A. Baltatzis, MD 8113 Harford Road Baltimore, MD 21234 16

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Hopk INS Boyusw WILL The form of the first BALTIMIRS JOHNS BAH, 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 9. Birthplece (State or Foreign Country) Turicey 8. Date of Birth (Month, Day, Year) 1 M 2 T F Days Hours 212-22-8989 July 15,1911 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1 Tyres 2 No 10e. Street end Number 10f Zip Code 10g. Citizen of What Country? 636 Umbra Street 21224 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: 3€Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodosios Koutsodimos Trana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) James Demetrakis / Son 13715 Summer Hill Dr., Phoenix, Md. 21131 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from Stete 4 □ Donation 5 □ Other (Specify) Greek Orthodox Cemetary 7-11-98 Balto., Mo. 21. Sign fure of Funerel Service Licensee 22. Name and Address of Fecility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc. uanta OK Thomas 2134 Willow Spring Rd., Balto., Md. 21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, should be represented in the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Massive Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events Due to (or es a consequence of) Due to (or as a consequence of): resulting in deeth) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? INSIOX 24a. Was an autopsy performed' 1 Tyes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

The lew requires that the death certificate be exa Box 68760. P.O. of Vital Records, Physician: After Division or Attending 24 hours efter death.

Funeral Director: A filled in by

Physician /Medical

Examiner

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Director

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Completed

Funeral

Director

ral", or itema 23a or 28a-f show Examiner rount be notified at

The Medical

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permit. Peges 1 and 2 shou Depertment of Health and M important: If item 27 Is mart any Injury or other traumati

Physician

/Medical Examiner

Peges 1 and 2 should be filed within 72 hours effer death vent of Health and Mental Hygiene. Ont of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or Itema 23

Saltimore, Maryland 21215-0020

Physician/Medical Examiner Periphiphered Vascular ģ Completed 25. Was cese referred medical Be 1 Yes Certification: To 27. Manner of Deeth 5 Pending investigation Naturel 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier Medical

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

30. Name and # npleted cause of death (Item 23e) (Type, Print)

32. Registrar s Stonature

- Guna Dandson

Schar R BURTUN MAD
31. Dete filed (Month, Day, Year)
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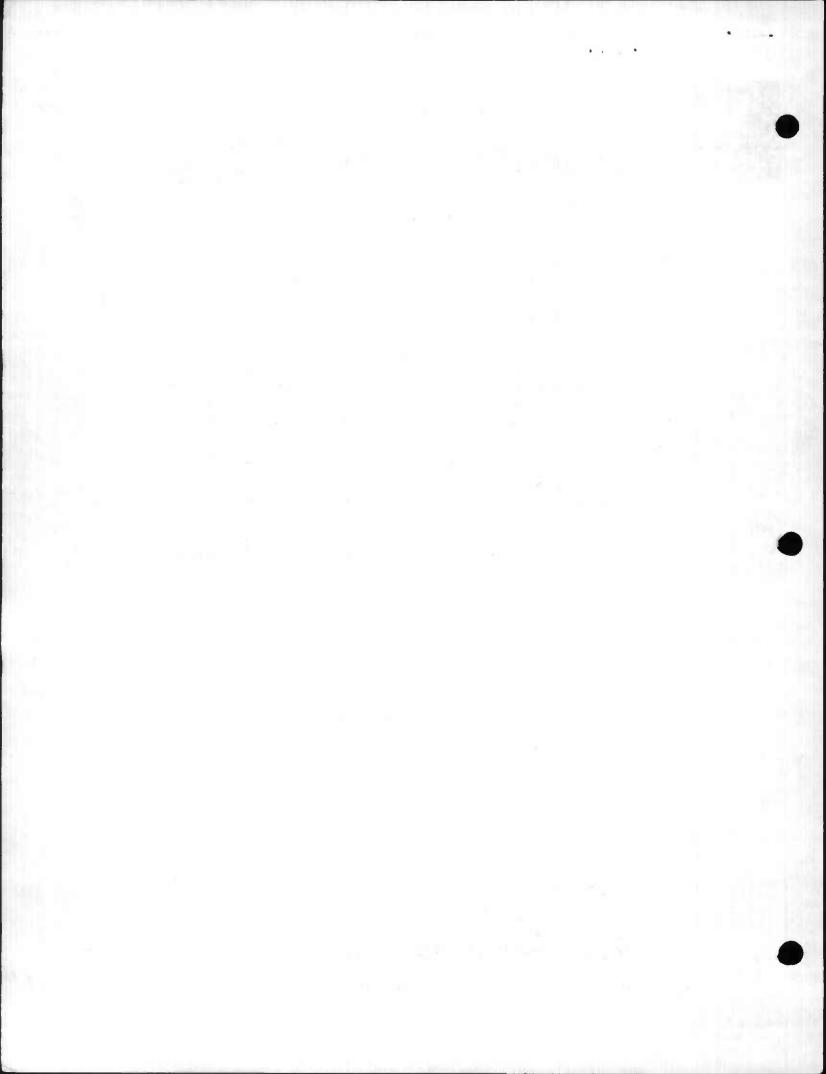
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State Registrar

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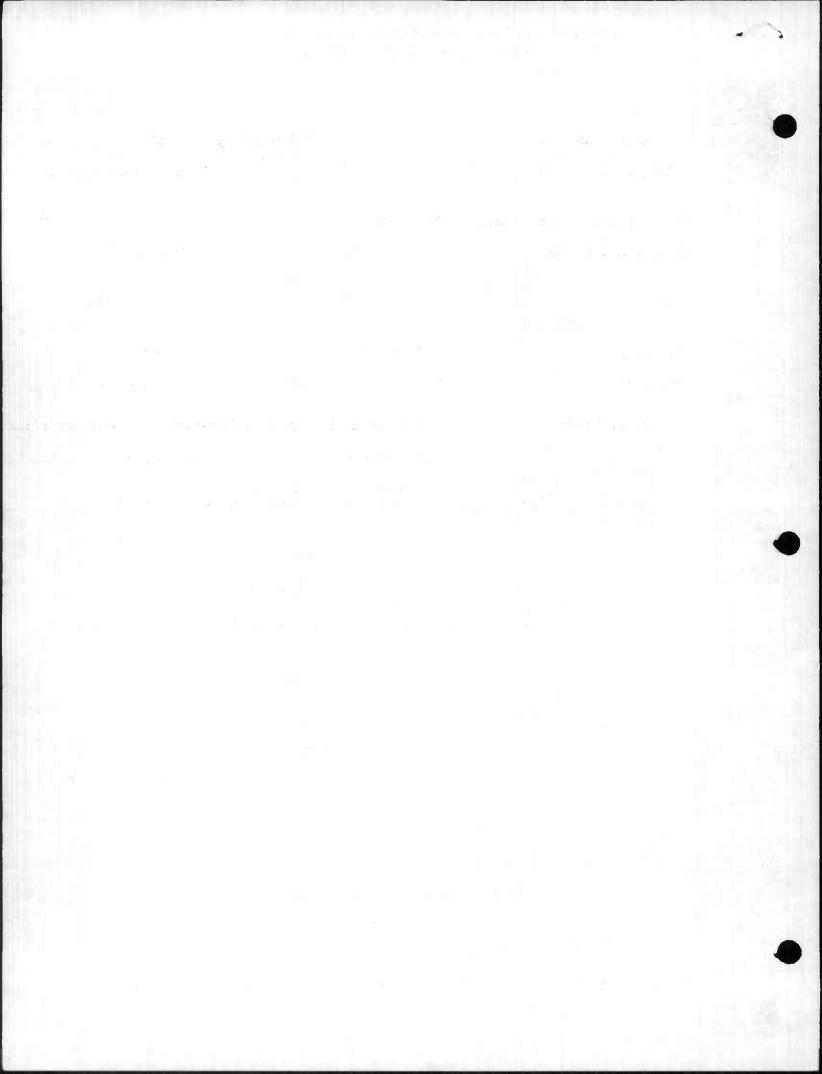
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Hospital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Mary	rialiu / i				20	21	310	
	Physici	an	Decedent's Neme (First, Middle, Last)				2. Date of Dea	Day	Yeer	3. Time of Deeth	
Ļ	/Medi	cai	Edward E. Druck			45 O'A Tarrent	-	1		10:58 A.M.	
	Examir	ner	4a. Facility Name (If not institution, give street end number) Johns Hopkins Bayview		1			1,000	Death		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In			If Under 24 Hrs.			9. Birthple Count Penns	ace (State or Foreign ly) Sylvania	
	and w		Usual Residence of Decedent 10a. State 10b. County 10	c. Citv. Tow	n or Location				16	Od. Inside City Limits	
	Meryl red	to		-						1 ☐ Yes 2 ☑ No	
	and 21215-0020 be filed within 72 hours after deeth with the Menyland hal Hygiene. d other than "natural", or frems 23s or 28s-f show event, the Medical Example must be morified at	Director	10e. Street and Number		10f. Zip Code	-		-	hat Count	ry?	
		rai	95 S. Franklin Street								
21215-0020	al', or Item	by Funeral	11. Meritel Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Wes Decedent Eve Armed Forces? 1 □ Yes ∑∑ No If Yes, Give Year or Dates:	in U,S.			ecify Yes or No- Rican, etc.)	14. Race Black Specify:		etc.	
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a	Decedent's Usual Occup (Give kind of work done	pation during most of work	ing	16b. Kind of Bus	Iness/Ind	ustry	
121	within ene.	Completed	Elementary/Secondery (0-12) College (1-4or 5+)	Ma		ed)		Machine	Shor		
	il Hygie other i	Be Co	8th Grade 17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle.				
Maryland		ToE	William	Druck		Mary		Fi	Fisher		
Mar	12 sh h and h and lis m traum		19a. informant's Neme/Relationship (Type, Print)								
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Baltimore,	pemit. Pages 1 e Department of Hee Important: if Item any injury or othe once.		21. Signature of Funeral Service Licensee				3				
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	Discolator		23a. Parti. Inter the disease, or complications that caused the shoot. A heart failure. List only one cause on each line.	death. Do	not enter the mode of dyl	ing, such es cardiac	or respiratory ar	rest,		Approximete Interval Between Onset and Death	
*	Physician /Medical	13	Immediate Cause (Final disease or condition		ano 4.	,			10	· · · · · · · · · · · · · · · · · · ·	
	Examiner	Į,	resulting in death)			, and			VI	way	
7	pet list	Examiner	o. 7 Cou	and .	ry Heart	Orsea	re		14	lears	
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68760,	ificete of executed g physician and es the buriel-transit	edicai		to (or as e	consequence of):	9 100	Lui		1	reary	
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la E			25. Was case referred to medical						1 🗆	Yes K No	
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Division of	ng Phi ther thi		27. Menner of Death Death Sugarral S □ Pending (Month, Dey Ye	Ab. City, Town, or Location of Death Ac. County of Death Ab. City, Town, or Location of Death Ac. County of Death Ac. Coun							
200	death. ctor: Al	catle	2 Accident Investigation		M 1		701 1 711 71	/			
D N	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	4 Homicide determined 256. Place of Injury building, etc. (S	pecify)			City or Tow	n, Stete)			
	Hosp 24 hou Funei stely fill	edical	(Check only 2 Medical Examinar: On the basis of exa	knowledge mination an	e, death occurred at the the	me, date and place, opinion, death occur	and due to the d red et the time, d	cause(s) and man dete end place, an	ner as sta nd due to	ited. the cause(s)	
	Nithin Fo the comple	Mec	29b. Signature end title of certifier		29c. Licens	se number		29d. Date signed	(Month, C	Jey, Year)	
	->-0		> Stellow Cont. Will les	Card	colgist DI	16362	MD	14 tul	4 19	68	
	6		30. Neme and address of person who completed cause of death	(Item 23e)	(Type, Print)				717	24	
	CIO		Sheldon H. Gottles, W 49 31. Date filed (Month, Dey, Year) 32. Regiment	40	costern,	1the 13	raltim	ore wy)	210	07	
	Sta Registr		1111 1 6 1998	Davidso	- Mandell						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death

					Ce	ertifica	te of	Death		Re	eg. No.	6-	1011	
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/Medical		a Fecility Neme (If not institution, g	ive street and num	ber)				4b. City, To	wn, or Lo	cation of Deeth	4c. County		0.20 2.	
Examiner	ľ	Franklin Square			er		1	Rose	da1e			altim	ore	
	5				. last birthde	y) If Und	er 1 Year						olece (State or Foreig	
neral ector		216-10-1116 Jsuel Residence of Decedent	113 M 2□ F	87	Yrs.	Months	Deys	Hours	Min.	8. Dete of Birth (Month, Dey, May 29	1911	Ma	ryland	
E m		10a. Stete 10b. County		10c. C	ity, Town or I	Location							10d. Inside City Limit	
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n, the Medical Examiner must be notified Completed by Funeral Director	1	10e. Street end Number 10f. Zip Code 2109 Oak Road 21219								1	Og. Citizen of United			
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by Fu		1 Never Married 2 Merried 3 Widowed 4 Divorced		No.		1 Yes			, 1 00110	mount oto./	Specif		White	
2		15. Decedent's	Education		16e. Dec	edent's Us	uel Occu	petlon		T	16b. Kind of B	usiness/In	dustry	
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r traum		19e. Informent's Neme/Reletionship Mrs. Ida E. Ell				iling Addre				re, Mar		Stete, Zij 2121	_	
oth	2	20e. Method of Disposition		20b.	Plece of Dis	position (N	eme of	ace)		Dete	20c. Location	- City or T	own, State	
jury or		1 ☐ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec	cify)	Hi Hi	illtop Service Corp. 7/1							son, Maryland		
important: if item 27 is merked other than "hatues", or takes 23s or 28s-1 show any Injury or other traumatic event, the Modifiel Examples must be notified as once. To Be Completed by Funeral Director	1	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Duda-Ruck Funeral Home of Dur 7922 Wise Ave. Dundalk, Mary												
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should be det										24e. Wes e	n eutopsy		Vere autopsy findings	
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d in by ti		3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)							28f. Location (S City or Town	treet and Num n, State)	ber or Rui	ral Route Number,		
completely filled in by the funeral Medical Certification:		29a. Certifier Check only one)	Physician: To the base	is of examin	owledge, de atlon end/or	eth occurre Investigetion	d et the	ime, dete en opinion, dee	d plece, th occurr	end due to the c	euse(s) and nate end pleca	anner as , end due	stated. to the cause(s)	
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death 340 Howard **Engelke** JULY 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health Care of Bel Air Bel Air Harford If Undar 1 Yaar Months Days If Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) 3-29-14 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) MD 17€M 2□F 84 212-09-2148 Yrs. Usuai Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits Harford White Hall 1 ☐ Yas 2 ☐ No 10e. Street and Number 10f. Zip Coda 10q. Citizan of What Country? 2919 Bradenbaugh Rd. 21161 USA 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☑ Yas 2 ☐ No If Yas, Giva Yaar or Datas: WW II 1 Nevar Married 2 Married Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 6 Fire Fighter Public Service 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) August Engelke Anna Pfiefer 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 8522 Westerman Cr. Perry Hall, MD 21236 Ken Engelke / nephew 20b. Placa of Disposition (Nama of comatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata Bel Air Memorial 7-16-98 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 23a. Part1. Enter the disease, or complications that caused in death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Betw Immediata Causa (Final disaasa or condition rasulting In death) Obstructive Phlmonory Dilles 10 yruns Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Ware sutopsy findings available prior to completion of cause of death? 1 Yas 2 No 1 Yas 2 No 26. Placa of Death (Check only ona)

Physician /Medical Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martial Hygiene.
Important: If item 27 is marked other than "netural" or items 23a or 28a-f ahow any Injury or other traumatic event, the Hydrel Exercise.

Physician/Medical Examiner Sequentially list conditions, if any, laeding to immadiate causa. Enter Underlying Causa (Disaasa or Injury that initieted evants rasulting in death) Last

> 25. Was casa rafarred to medical axaminar? 1 Yas 2 No 27. Manner of Death

1 Inpatient 5 Panding Invastigation

6 Could not be

Data of Injury (Month, Day Year)

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 Yas 2 No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one)

1 Natural

2 Accident

3 ☐ Sulcida

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar

29c. Licansa number

29d. Data signed (Month, Day, Year)

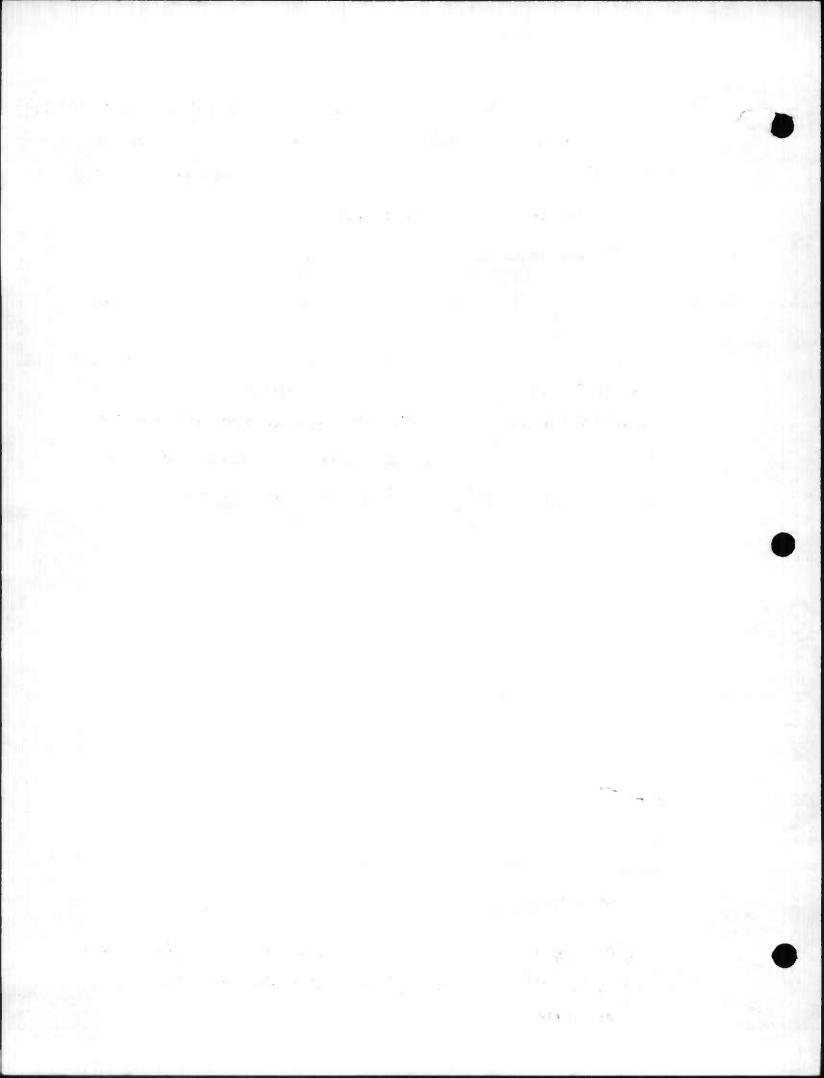
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D34452

State Registrar

North Avenue Bil Air Manyland 21014 32. Ragistrar's Signatura Julia Davidson-Randelle

DHMH 16 Rev 6/95



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			Oldie of IV	aryland / L	Certificate of			Reg. No.	2	1813	
Dhysisian	Decedent's Name (F.	irst, Middle, Lest)				2. Data of Dea Month	ath Dey	Yeer	3. Time of Death		
Physician /Medical	SYLVIA		Р.		FRIEDMAN		JULY 12	2, 1998		12:10 PM	
Examiner	4a Facility Name (If no	institution, give s	treet and number,)		4b. City, Town, or L	ocation of Death	4c. County	of Death		
			NURSING I			BALTIMO			ALTI		
Funeral	5. Social Security Numb		M 2X F 7. A	ge (In yrs. last bir	Months Days		8. Data of Birt (Month, De)		9. Birthpl	ace (State or Foraign try)	
Director	219-01-469	98	W 6.439 T	91	Yrs.		NOV.	9, 1906		MD	
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	11. Marital Status		2. Was Decedent	Ever in U,S.	13. Was Decedent of If Yas, specify Cu				- America	an Indian,	
5-0020 72 hours after dea natural, or frems deal Examine meted by Funel			Armed Forces' 1 Yes 2X If Yes, Give Year or Detes:	No	If Yas, specify Cu		Ricen, etc.)	Specify:	k, White, o	etc. ITE	
21215-0020 de within 72 hours af giene. The matural, or then matural, or the worldest Exemple to the completed by F		Decedent's Educ			Decedent's Usual Occu	upation		16b. Kind of Bu	siness/inc	lustry	
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Maryla de should	19a. Informant's Name	Relationship (Ty)	oe, Print)	198	. Mailing Address (Street	et end Number or Ru	rel Route Numbe	er, City or Town,	Stete, Zip	^{Code)} 33436	
E TO N	GERALD I	RIEDMAN	(SON)	11	211 S. MILI	TARY TRAI	L #413 1	BOYNTON	BEAC	H, FL	
2 2 2 2 2	20a. Method of Disposit	remation 3 🗆 R	emoval from State	cemete	Disposition (Nema of ry, cremetory or other pi ION TIFERET		Date 7/14/98	20c. Location -			
Baltimo	4 Donation 5 21 Signature of Funera		190	O DAIX Z			- 1				
Balti permit. Departm Importar any Inju	22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD PIKESVILLE,										
	23a. Pant Enter the dishock or mart fa	isease, or compli ilure. List only on	e cause on each	d the death. Do line.	not enter the mode of dy	ying, such as cerdiac	or respiretory ar	rest,		Approximate Interval Between	
Physician				1						Onset and Daath	
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) a. hypotensian dehydruhon Due to (or as a consequence of): Severe Organic brain syndrome.								1	2 weeks	
-									1		
nine				perere	Organic	brain	Dyna	rone.			
10	Sequentially list conditi if any, laeding to imma ceuse. Enter Underlyin Cause (Disease or Inju	ons,		Dua to (or as a	consequence of):				i		
3	ceuse. Enter Underlyin Cause (Disease or Inju- that initiated events	y d	C								
S87	rasulting in deeth) Last			Due to (or es a	consequence of):						
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P.O. that the de by the detached	Part II. Other significan	it conditions con	tributing to death I	but not rasulting i	n the underlying cause of	given in Part I.				the cause of death?	
dS, P signed by d be detailed by Pt	Ca	break	2				,,,	Yes 2 No	3 P10	bably 4 Onknown	
I Records, P.O. Be The law requires that the death the has been signed by the atter bage 2 should be detached for completed by Physicial	0	11.	pem		1		24e. Wes	en eutopsy	24b. W	ere autopsy findings	
cord	12	U 110W	pem	ph 1601	-0		peno	med?	co	ailable prior to mpletion of ceuse deeth?	
The law require tate has been sing page 2 should Completed							10	Yes 20No		Yes 2□ No	
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ion o iding Ph ith. After th funeral	1 Naturel 5	Pending investigation	(Month, D	ey Year)		fork? □Yes 2□No					
Atter dea ctor yy the	3 ☐ Suicida 8	Could not ba						28f. Location (Street end Number or Rural Routa Number,			
din to	4 Homicide determined building, etc. (Specify)										
Division of To the Hospital or Attending P within 24 hours effer death to the Funeral Director: After the completely filled in by the funeral Medical Certification:			er: On the basis	of examinetion er	e, death occurred at the ad/or investigation, in my						
ithin 2 of the omple of the omp		of certifier	and manner s	taleu.	29c. Lice	nse number		29d. Date signe	d (Month,	Dey, Year)	
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0	30. Neme end eddress	or person who co	ripleted cause of	GUERT (ITEM 236)	(Type, Print)	11/2	ma	2/11.	7		
State	31. Date filed (Month, L	Day, Year)	32. Regist	trer's Signeture	1.51			- / / /	/		
Registrar	ACT	161998	Statio	Davide	70.00						

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Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 1998 /2:15 AM 10, 1948 4c. County of Death Harry Austin Farson III 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Nov. 8, Nov North Arundel Hospital 7. Age (In yrs. last birthday) 53 Yrs. 5. Social Security Number 9. Birthplace (State or Foreign Year) 944 15 M 2□ F 220-42-6280 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4035 Twin Circle Way 21227 U.S.A. 12. Was Decedent Ever In U.S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merifel Status 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 1963 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown Warehouse 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Harry Austin Farson II Marjorie Noble Fowler 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Farson/wife 4035 Twin Circle Way, Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removal from State 4 Donetion 5 Other (Specify) 22. Name and Address of Fecility State Anatomy Board, 655 W. Baltimore Street Konald S Wade, Director Baltimore, Maryland 21201 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, spack, or heart failure. List only one cause on each line. Onset and Deeth Immediete Ceuse (Finat disease or condition resulting in death) Reiniratory Arrest and failure Due to (or es e consequence of): Metastatic Squanous Cell Carcinema of Lung Due to (or as a consequence of): Chronic Cigarette Smoking Left mainstern Bronchers Occhusion Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? Suproventricular tachycardia 24a. Was an autopsy performed? Hyper calcemia Ischeric Cardionyopo my 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one)

Physician /Medicai **Examiner**

Box 68760.

Division of Vital Records,

r death.

e Hospital or Attendi 1 24 hours after death. e Funeral Director: A

To the twithin 2

Physician

' /Medical

Examiner

Director

Funeral

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Maximi Examinat must be notified at

should be f nd Mental I

Pages nent of

Farson

Examiner attending physician and for usa as the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Physician/Medicai

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Be

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4 Homicide

John

31. Date filed (Month, Day, Year)

Superior Vena Cava Syndrome

Hospital: 1 □ npatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of tnjury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28c. tnjury et Work? 5 Pending investigation 1 Natural
2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and ptace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and ptace, and due to the cause(s) end manner stated. 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number

032654

MD se of person who completed cause of death (Item 23a) (Type, Print)

16 1998

301 Hospital Drive, Glen Burnie, mD 21061

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Yaar

Physician /Medical **Examiner**

Funeral Director

e filed within 72 hours after death with the Meryland of Hygiene. other than "natural", or flems 23s or 28s-f show traumetic event, the Medical Examiner must be notified at Nerns 23a d 2 should be fill hand Mentel H

21215-0020

Maryland

Physiclan /Medical Examiner

Division of Vital Records, P.O. Box 68760 The law requires that the death certificate signed by After this certificate has

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra-Baltimore, or Attending Physician: death. ours efter death. herel Director: A filled in by the fo To the Hospital within 24 hours a To the Funeral Completely filled

Month N. TEENDENNING KLIZABE TH, AN 8 4a. Facility Nama (If not institution, giva street and number 4b. City, Town, or Location of Death 4c. County of Death Keswick Nursing Home Baltimore N/A If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 □ M 2 🛛 F 219-30-5397 92 Yrs. Feb. 16,1906 Maryland Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Tas 2 No N/A Baltimore Director 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? Keswick Home, 700 W. 40th St. 21211 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ★□No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: þ Specify: 3∕DWidowed 4 □ Divorced white Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) Elementery/Secondary (0-12) Coilega (1-4or 5+) Homemaker 11 In Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) Be John Nunner 10 Caroline Altpater 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) Doris Kinch 4008 Belwood Avenue Baltimore, MD 21206 of Disposition (Nama of Data 20c. Location - City or Town, Stata Daughter 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 1 2 Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Spacify) Loudon Park Cemetery 7/15/98 Baltimore, MD 21. Signature of Junaral Sarvice/Licensee 22. Nama and Addrass of Facility Burgee-Henss Funeral Home, P.A. 3631 Falls Road Baltim (
e) or complications that caused the death. Do not anter the mode of dylng, such as cardiac or respiratory errest, List only one cause on each line. 3631 Falls Road Baltimore, MD 21211 Approximate Intervei Batwean Onsat and Death Immediata Causa Finai time central herneus suptem disease disaasa or condition rasulting in death) Dua to (or as a consequence of) Examiner Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in daeth) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 250 No 3 Probably 4 Unknown dealase accular by Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy complation of causa of death? 1 Yas 2 No 1 Yas 2 No Be (25. Was casa rafarred to medical 26. Placa of Death (Check only one) axaminar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 1 🗌 Yas 2 No 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Panding Invastigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarminad 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceusa(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, deta and place, end due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signatura and titla of cartifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number

State Registrar

31. Data filed (Month, Day, Year)

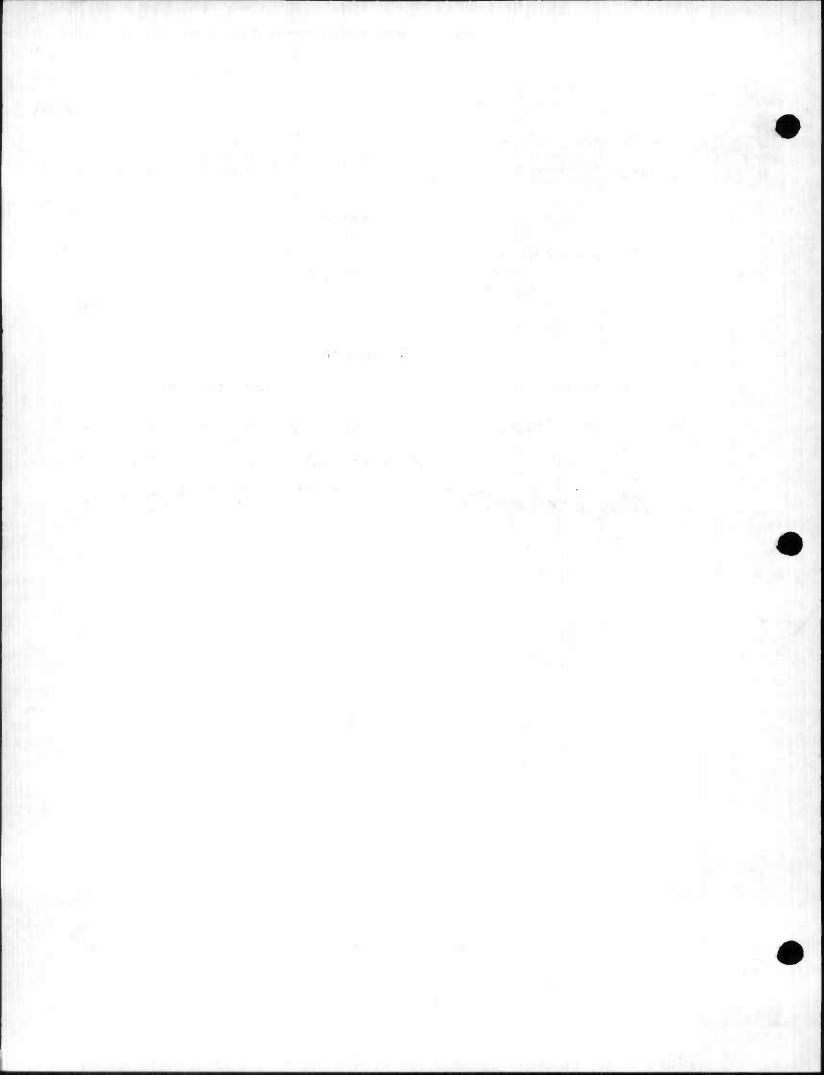
30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print)

M. ISABELLE MAESREGOR, KESWICK, 700 W 40 th STREET, BALTIMORE, MD 21211 32. Registral's signestice.

June Daydson-Randelle.

Tackege mo

Tuly 13, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** John Gerace 7:39 am James 13, 1998 /Medical 4b. City, Town, or Location of B 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Franklin alla(e aspita If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days 1X M 2 □ F Months Director May 2,1916 Pennsylvania 207-05-7046 82 Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or thems 23e or 28e-f show traumetic event, the Medical Examiner must be notified at Dundalk 1 Yes 2 No Maryland Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 2072 Jasmine Road Funer 12. Was Decedent Ever in U,S. Armed Forces? 1XI Yes 2 □ No If Yes, Give Year or Dates: WW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify ģ 3 ☐ Widowed 4 ☐ Divorced White WWII Completed 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elamentery/Secondary (0-12) College (1-4or 5+) Automobile Industry Automobile Assembler 12 Years 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Be Montal 2 Dominic Gerace Josephine Messina 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 2072 Jasmine Road Dundalk, Maryland Wife Glenna Gerace If Nom 27 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State Pages ъ Buriel 2 Cremetion 3 Removel from State b Gardens of Faith Cem. 7/16/98 4 ☐ Donelion 5 ☐ Othar (Specify) Rosedale, Maryland 21. Signeture of Funaral Service Licansee 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Aortic Aneurysm /Medical Immedieta Ceuse (Finel disease or condition resulting in death) Examiner Due to (or es e consaguenca of) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disaesa or Injury that initieled events resulting in death) Lest Due to (or as a consequence of): Physician/Medical physic the Due to (or es e consequence of): 950 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings eveilable prior to Completed 24a. Was an autopsy performed? peed completion of cause of death? has 2 No 25. Wes case referred to medical axaminar? Be 26. Plece of Deeth (Check only one) To. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas ZNO 2 ER/Outpatient 3 DOA 1 Inpatient this funeral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 Pending Invastigation 1 Naturel 2 Accident 1 Yas 2 No after death Director: 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 8 24 hours 1% Certifying Physician: To the best of my knowledge, deeth occurred et the time, dele end plece, end due to the ceuse(s) end manner es stated. 2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, dele end plece, and due to the cause(s) end manner steted. Medicai 29e. Certifier complataly (Check only one) To the twithin 2

Division of Vital Records,

ames Gerac

31. Data filed (Mont State Registrar

296. Signature and title of

30 Name and address of person

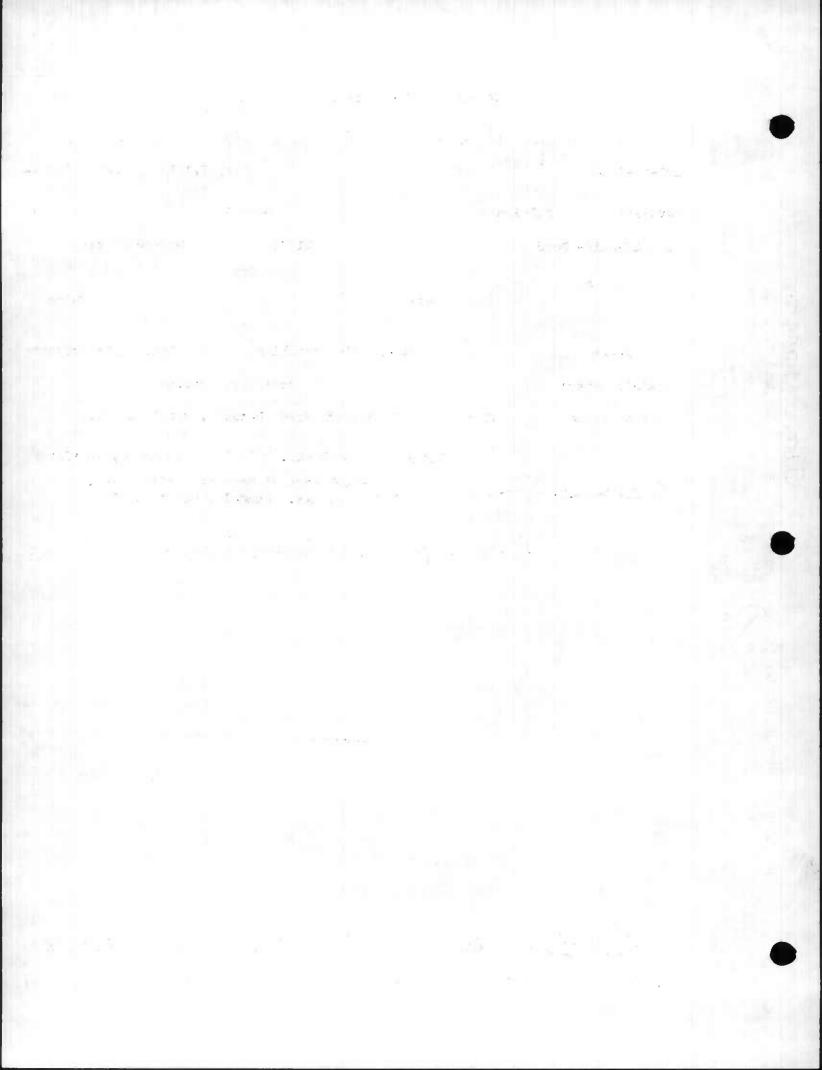
32. Registrer's Signeture whia Davidson

who complated cause of daath (Itam 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:14 pm 2, 1998 SUSAN B GRIFFITH 4b. City, Town, or Location of Death 4g Facility Name (If not institution, give street and number) 4c. County of Death Ltimore ranklin tospita uare 7. Age (In yrs. last birthday, Birthpleca (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1□M 2XF 218-68-5233 Yrs MARYLAND MARCH 20, 1957 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No BALTIMORE BALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 7806 BAGLEY AVE UNITED STATES 14. Raca - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MEDICAL Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL ASSISTANT SERVICES 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) JR JOAN YEACOCK THOMAS FREDERICK 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN P. GRIFFITH WILSON AVE FORK 21051 MOTHER 12703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY BALTIMORE MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Homs P.A. M00382 ALTENBURG FUNERAL 6009 HARFORD RD. 23a. Part1. Enfer the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one ceuse on each line. BALTIMORE MD 21214 Approximate Interval Between Onset and Death immediate Ceuse (Final disease or condition resulting in death) 75 Minus Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events that initieted events resulting in deeth) Lest Due to (or as a consequence of): 23b. Did tobacco use contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 12 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 28c. injury at Work? 28d. Describe how Injury occurred 5 Pending investigation

es the 080 signed by Division of Vital Records, 8 page 2 should certificate hes To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Funeral

Director

Item 27 is marked other than "natural", or itema 23a or 28a-f show other treumstic event, the Medical Examiner must be notified at

Il Hygiene.

end Mental Hygin

Department of Heeith Important: If Item 27

Physician

/Medical

Examiner

Physician/Medical Examiner

p

Completed

Be

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Certification:

Medical

any injury or

juston Griffith

1 Yes 2 No 27. Manner of Death 1 Neturei

25. Was case referred to medical examiner?

2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify)

1 Yes 2 🗌 No

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

ause of deeth (item 23a) (Type, Print)

JUL 1 6 1998

Franklin-Square 9000 31. Date filed (Month, Day, Year) 32. Regist

State Registrar

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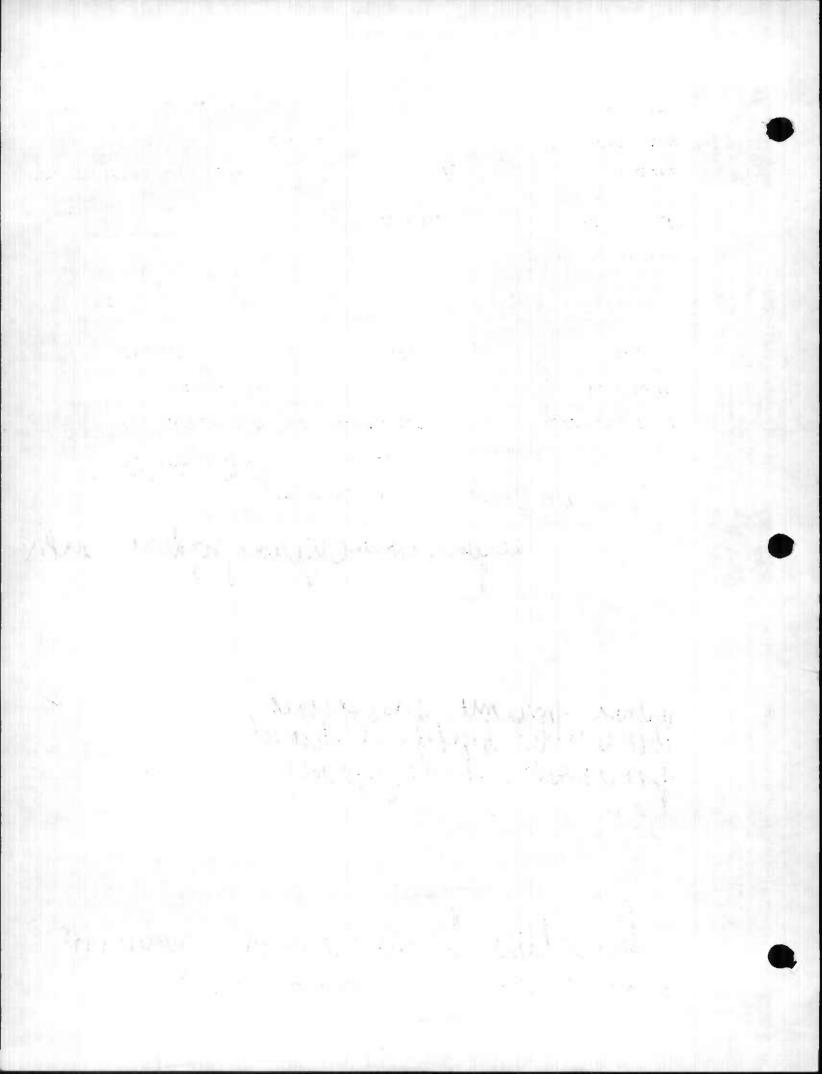
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State of Maryland / Department of Health and Mental Hygiene 98

			(Certificate	of	Death		Reg. No.		41010		
	1. Decedent's Name (First, Middle, Last						2. Date of D	eath Day	Year	3. Tima of Death		
Physician Medical	ROBERT	GOUDN	M				JUL	12	1998	938 DM		
Examiner	4a Facility Name (If not Institution, give	street and number)				4b. City, Town	, or Location of Dea	th 4c. Cour	nty of Death			
	SINAI HOSPITAL						ALTIMORE			N/A		
Funeral	Social Security Number 6. Se	X 7. Ag X M 2□ F	e (In yrs. last birth	Months	Year Days	If Under 24 Hours	Hrs. 8. Date of E Min. (Month, I	lirth Day, Year)	9. Birthp	place (State or Foreign		
Director	131-12-1121	201	70 Y	rs.			MAY 1,	1928		NJ		
pu *	Usual Residenca of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	IOd. Inside City Limits		
Aarylar f show	MD BALTIM	ODE			DAT	штиооп				1 ☐ Yes 2X No		
or 28a-f sho	MD BALTIM 10e. Street and Number	JRE		10f. Zip (_	TIMORE		10g. Citizen o	f What Cour	ntry?		
fier death with the Manyland r term 23a or 28a-f show first must be notified at Funeral Director	6601 PIMLICO ROAL				2	1209	11	S.A.				
death and a	11. Marital Status	Ever in U,S.	13. Was Decede	ent of H		? (Specify Yes or Puerto Rican, etc.)		ece - Americ				
		Armed Forces?	No NTRAFT				'uerto Hican, etc.)		leck, White,			
S I G		1 X Yes 2 ☐ I If Xes, Give Year or Dates:	NAVY	1□ Yes 2	ĎŽ №0	Specify:		Spec	iify:	WHITE		
	15. Decedent's Edu (Specify only highest grad	cation le completed)	/	Decedent's Usual	done	during most of	f working	16b. Kind of	Business/In	dustry		
	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use								
al Hygier ti vent, the		5+		PHYSICIS	T -		PACE Name (First, Midd			ETTA CO.		
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		and manner st					l at the time, date and piace, and due to tha cause(s) 29d. Date signed (Month, Day, Year)					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** JUNE 21, MICKEL GIBSON 1998 6:40 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSP. CHEVERLY If Undar 24 Hrs. Birthplaca (Stata or Foreign Country) If Under 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours 1 ★M 2 F 37 Yrs. 577-9411-89 APRIL 26 1961 Director washington D.C. Usual Residence of Decedant the Marylend 10c. City. Town or Location 10d. Insida City Limits 10a. State 10b. County must be notified at 1 □ Yes 2 □ No Directo P.G NEW CARROLLION MD. 10e. Street and Number 10f. Zip Code 10g. Cifizan of What Country? with 8317 CARROLLION PARKWAY 20784 Funeral USA Pages 1 and 2 should be filed within 72 hours after death ment of Health end Mental Hygiene.
ant: if Kem Z71s marked other than "naturel", or Kema 23 ant: if kem creaments event, tra Medical Examiner massury or other traumatic event, tra Medical Examiner mass Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status 12. Was Decedant Evar In U.S. Armed Forces?
1 ☐ Yas 2 → No Black, White, atc. 1 Nevar Married 2 Married If Yas, Give Year or Datas: 1 Yes 250No Specify: Specify: by 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) 11TH LABOR RESIAI RANT 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middla, Last) ANDREW GIBSON ANELL WASHINGTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) ALICIA BLAINE/SISIER 8317 carrollton parkway new carrollton MD. 20784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If I eny Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Mr. ZION CEM. 6/27/98 BALTO MD. 22. Nama and Address of Facility TRT SIATE FUNERAL SERVICES INC. 21. Signature of Funaral Sarvice Licensee 814 UPSHUR ST. N.W sommer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath **Physician** Immediata Cause (Final disease or condition rasulting in death) /Medical Examiner Examinet physician end the bunal-transit The law requires that the death certificate be axecuted Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disease or Injury Due to (or as a consequence of): P.O. Box 68760 Physician/Medical that initiated avants resulting in death) Last Dua to (or as a consequence of): 88 esn 0 signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part i 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Division of Vital Records, þ been sig 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of daath? Completed has certificate ha 1 ☐ Yes 257No 1 ☐ Yes 2 5 No Physician: Be 25. as case referred to medical 25. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 2 SOI DOA 2 ER/Outpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: or Attending 5 Panding 1 Yas 2 No r death. 2 Accident ector: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hour. the Funeral Direction of the filled in by 3 4 Homicide 29a, Certifie 1 (If certifying Phyeician: To the best of my knowledge, death occurred at tha time, date and place, and due to the causa(s) and menner as stated. edicai 2 Medical Examiner: On the basis of exa (Check o nination and/or Investigation, In my opinion, death occurred at the time, data and place, and due to the cause(s) poted. To the I within 2 To the I 29d. Data signad (Month, Day, Year) 29b. Signati 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) RNNI 5 ar's Signature W15 30001 HOSPITAL DR. CHEVERLY MD. 32. Ragistrar 1 6 1998 31. Date filed /Mo State the Davidson Registra



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year 8 **Physician** 12:30am H eckner 4a Fecility Neme (If not institution, give street end number, /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore N/A Hospita linai If Under 24 Hrs. 8. Dete of Birth Mar. 4,1907 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (Stete or Foreign **Funeral** 10 M 21XF Months Days Hours Min. Maryland 91 Yrs 220-46-0439 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be monited at Maryland N/A Baltimore 1 Yes 2 No Director 2211 W. Rogers Avenue 10f. Zip Code 10g. Citizen of Whet Country? 21209 Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Reca · American Indien. Black, White, etc. 1 Never Married 2 Married Specify White 1 Yes 2 No Specify: p 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Busineas/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiane. Eiementery/Secondary (0-12) Unknown Coilege (1-4or 5+) Homemaker Own Home Patient Known 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Harry E. Coursey Lillie Baxter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st. Department of Heelth and Important: If Item 27 Is m any Injury or other traum once. 19e. Informant's Name/Relationship (Type, Print) The Wesley Home 2211 W. Rogers Avenue, Baltimore, Md 21209 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 2☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 7/7 Woodlawn, Maryland 4 Donation 5 Other (Specify) Burgee-Henss Funeral Home PA 21. Signeture of Funeral Service License 3631 Falls Road, Baltimore, Maryland Entor he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or the failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical · Complications following extended right hemicolectiny 15 days Examiner Examine Cartificatortica attanding physician and for use as the bunel-transit certificata be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury Physician/Medical that initiated events resulting in death) Lest Due to (or as e consequenca of): P.O. 23b. Did tobacco use contribute to the cause of death? the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 6 Records, by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? The law paga 2 certificata has 2 N No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending investigation ours eftar death. eral Director: Aft filled in by the fur 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completaly filled Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

State Registrar

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29a, Certifier (Check only one)

29b. Signature and title of cartifier

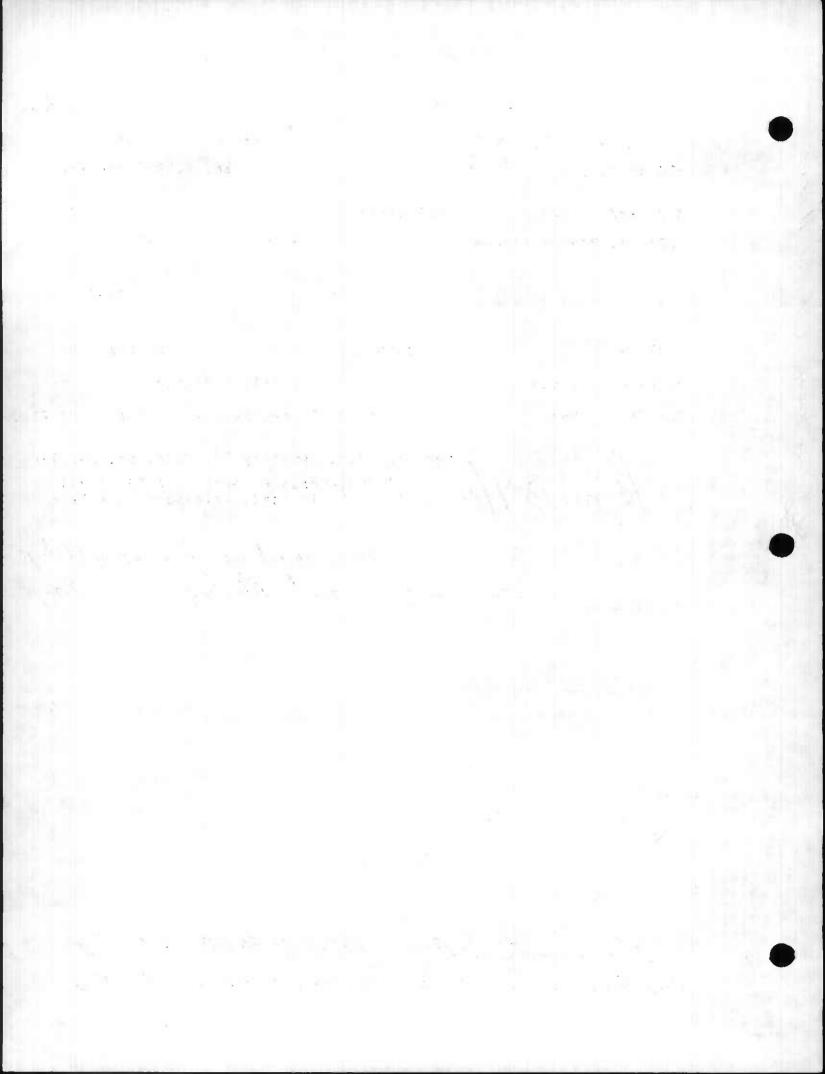
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30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

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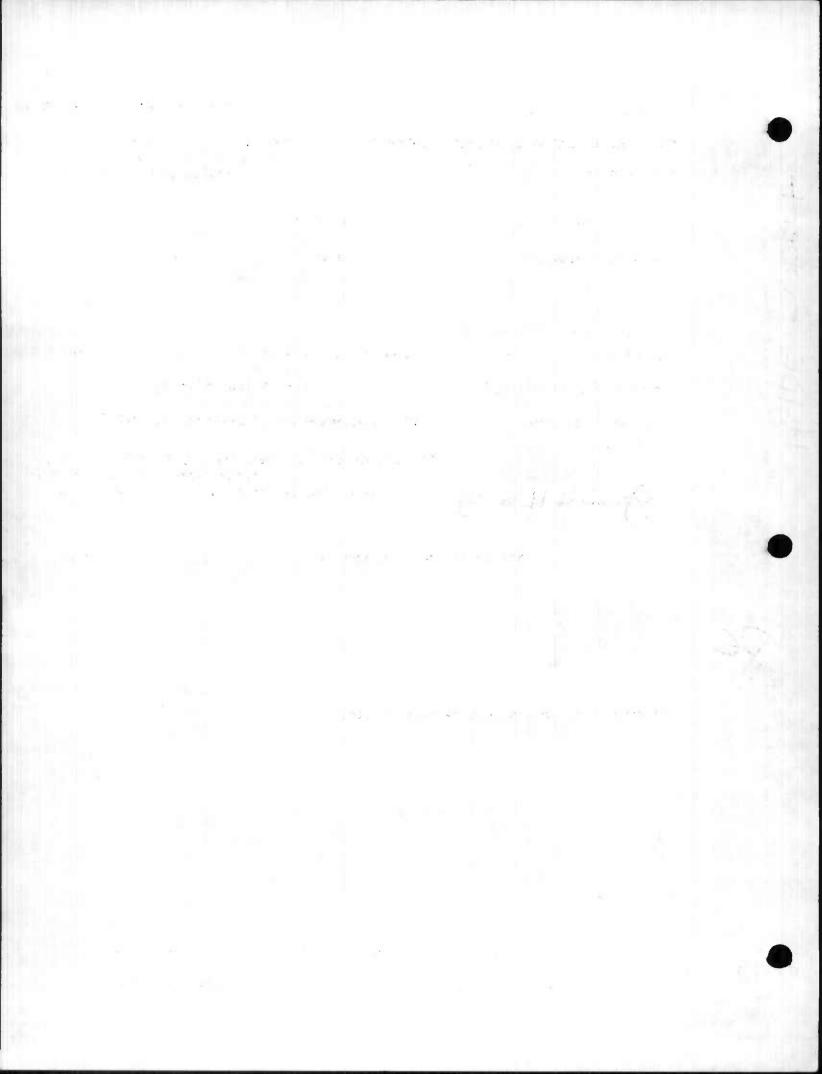
29d. Dete signed (Month, Dey, Year)

Plany #831 Baltimore, MA



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** JULY 12 1998 5:55 pm Robert Francis Hyde /Medical 4b. City. Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2□ F Months Hours 80 Jan.08,1918 Maryland Director 217-09-9124 Usual Residence of Deceden 10d. inside City Limits 10c. City. Town or Location 10e State 10b. County r 28a-f show 1 ☐ Yes 2K No Directo Villa Nova Md. Baltimore å 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "natural", or liams 23s or the Medical Examiner must be. United States 21207 4017 Villa Nova Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 No 15 Yes 2 No 15 Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. other than "o Elamentary/Secondary (0-12) Collaga (1-4or 5+) Electrical Designer Whitman Requardt & Ass. 12th Grade 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ed bluods Mental marked Sara Ellen Anderson Francis Abercrombie Hyde 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 8 Pages 1 and 2 4017 Villa Nova Road: Baltimore, Md. 21207 Item 27 Mrs. Betty L. Hyde 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State ъ Department of Important: If it 1 Burial 2 Ocremetion 3 Removal from State ò Baltimore/Washington Crem. 7/17/98 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Loring Byers Funeral Directors 21. Signature of Funeral Service Licensee 8728 Liberty Road; Randallstown, Md. 21133 H.EC. Approximete Interval Between Onset and Death 23a. Part En ar the disease, or complications that ceused heart failure. List only one causa on each line he death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical a Bilateral bronchopneumonia days Examiner Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): Physician/Medical that initiated evants resulting in deeth) Lest Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.0. 1 Yee 2 No 3 Probably 4 Unknown The law requires that end stage kidneys, congestive heart failure by 24b. Wara autopsy findings evellable prior to been signated 24a. Was an autopsy performed? Completed completion of ceuse of death? page 2 s ty Yes 2□ No 1√2 Yes 2□ No certificata Division of Vital Physician: 25. Was casa rafarred to medicel examiner? Be 28. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To C 1 Yes 2₺ No this : After this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: or Attending 1 SNatural 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation 2 Accident Director: / 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide aftar To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier 🙀 Certifying Physician: To tha bast of my knowledge, death occurred at tha time, date and placa, and due to the cause(s) and manner as atatad. edical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier an warm ear D30206 07/13/98 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Steven H. Pearlman, - GBMC 6701 N Charles St; Baltimore 21204 M.D. 31. Date filed (Month, Day, Year) 12 Registrar's Signeture State Registrar



BALTIMORE
If Under 24 Hrs. 8. Date of B
Hours Min. (Month, D NURSING HOME KNOLLS RVINGTON NIA 8. Date of Birth (Month, Day, Year) MAY 20, 1908 If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2×F 2/2-/8-4752 Usual Residence of Decedent Yrs Director MARYLAND the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Movical Examinar must be notified at 1 Yes 2 No Director MARYLAND 10e. Street end Number 10g. Citizen of What Country? 2017 BENTALOU STREET 21216 14. Race - American Indian, Black, White, etc. Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritai Status Never Married 2 Married 1 ☐ Yes 2 ♣ No It Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: BLACK ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiena. Important: If frem 27 is merked other than "n any injury or other traumate. Elementery/Secondery (0-12) 8+++C-RANE College (1-4or 5+) HIGRADE WORKER PRIVATE HOMES DOMESTIC 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be WALTER CORBIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER) 2017 N. BENTALOU STREET BALTIMORE, HD, 21216
20b. Place of Disposition (Name of Date 20c. Location - City or Town, State MARY WALKER 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removel from State HT. ZION CEMETERY 7-17-98 LANSDOWNE, HARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee

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To the Funeral Director: After this cardific completely filled in by the funeral director, 25. Was case reterred to medical examiner? Be 28. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menneyot Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, tarm, street, tactory, offica building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 1084 MA 30. Name and address of person who combleted cause of death (Item 23a) (Type, Print) 6212 Sylcervine 32. Registre s Signade. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

4c. County of Death

JULY

4b. City, Town, or Location of Beath

3. Tima of Death

55 AM

1. Decedent's Name (First, Middle, Last)

-LEANORA

4e. Facility Name (If not institution, give street and number)

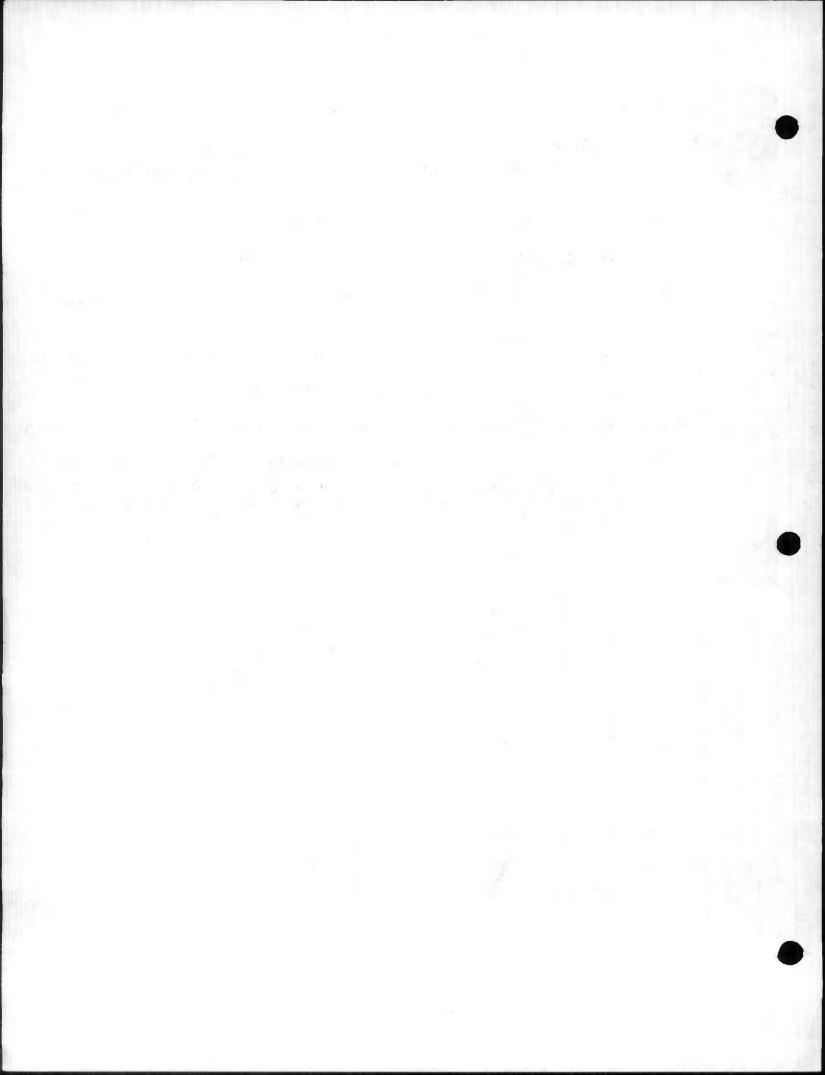
Physician

/Medical

Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Irwin Month Acacia 350 PM 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death Johns Hopkins Hospital Bathmore City If Undar 1 Yaar | If Undar 24 Hrs. 6. Sax 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (State or Foreign Country) Days Hours Months 1□ M 2₩ F Yrs. 220-39-0573 10/10/93 MARYLAND Usual Rasidanca of Dacedani 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No MD BALTIMORE RIDGELEIGH 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1744 JOAN AVENUE 21234 USA 12. Was Dacedanf Evar in U,S Armed Forcas? Was Dacadant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whifa, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva X Yaar or Datas: 1 Navar Married 2 ☐ Marriad 1 ☐ Yas 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedant's Education (Specify only highest grade completed) 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) N/A N/A 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) CHRISTOPHER E. IRWIN DIANE L. BRECHER 19a. fnformant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRIS IRWIN 20a. Mathod of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) BALTIMORE, MD 21234 20c. Location - City or Town, State FATHER 1 □ Burial 2 □ Cramation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify) DULANEY VALLEY MEM. GAR. 7/20/98 COCKEYSVILLE, MD 21. Signature of Funaral Service Licenses 22. Nama and Addrass of Facility JOHNSON FUNERAL HOME, P.A. 21286 Approximate Interval Batween Onsat and Death 8521 LOCH RAVEN BLVD. TOWSON, MD anter the mode of dying, such as cardiac or respiratory arrest. Mar tha disease, or complications that caused the death. Do not enter, or heart failure. List only one cause on each line. Immadiata Causa (Final Respiratory Failure disaasa or condition rasulting in daath) 30 min Dua to (or as a consequence of) Alveolar Rhabdomyosarcoma 2 years Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or Injury that Initiated avents Dua to (or as a consequanca of): that initiated avents rasulting in daath) Last Dua to (or as a consequanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy performed? 2 No 1 ☐ Yas DELNo 26. Placa of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding 1 Yas 2 No invastigation 28e. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

Physician/Medical Examiner Box 68760 The law requires thet the deeth certificant been signed by the attai o 9 Records, certificete Division of Vital or Attending Physician; funeral director. this After death. after death Director:

Physician

/Medical

Examiner

Directo

by Funeral

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examines I must be not lifted at

Peges 1 and 2 should be filed within 72 hours after onent of Heelth end Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Item

Hygiene.

permit. Peges 1 and 2: Department of Heelth er Important: If Item 27 is any injury or other traugnts.

Physician /Medical

Examiner

21215-0020

Baltimore, Maryland

by Completed 25. Was casa referred to medical Be 1 Yas 2 No Certification: To 27. Mannar of Death Natural 2 Accident 3 Sulcida 4 | Homicida

6 Could not be datarmined

28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 1 Certifying Physician: To tha bast of my knowledge, death occurred at the time, date end placa, and dua to tha causa(s) and manner as stated

(Check only one) 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of cartifiar

29a. Cartifian

Medical

State

29c. Licansa number

29d. Data signad (Month, Day, Year)

7/14/98

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

colleen McDonough, MD 31. Data filed (Month, Day, Year)

JUL 1 6 1998

32. Ragistrar's Signatura Lulia Tavidon-Randoll

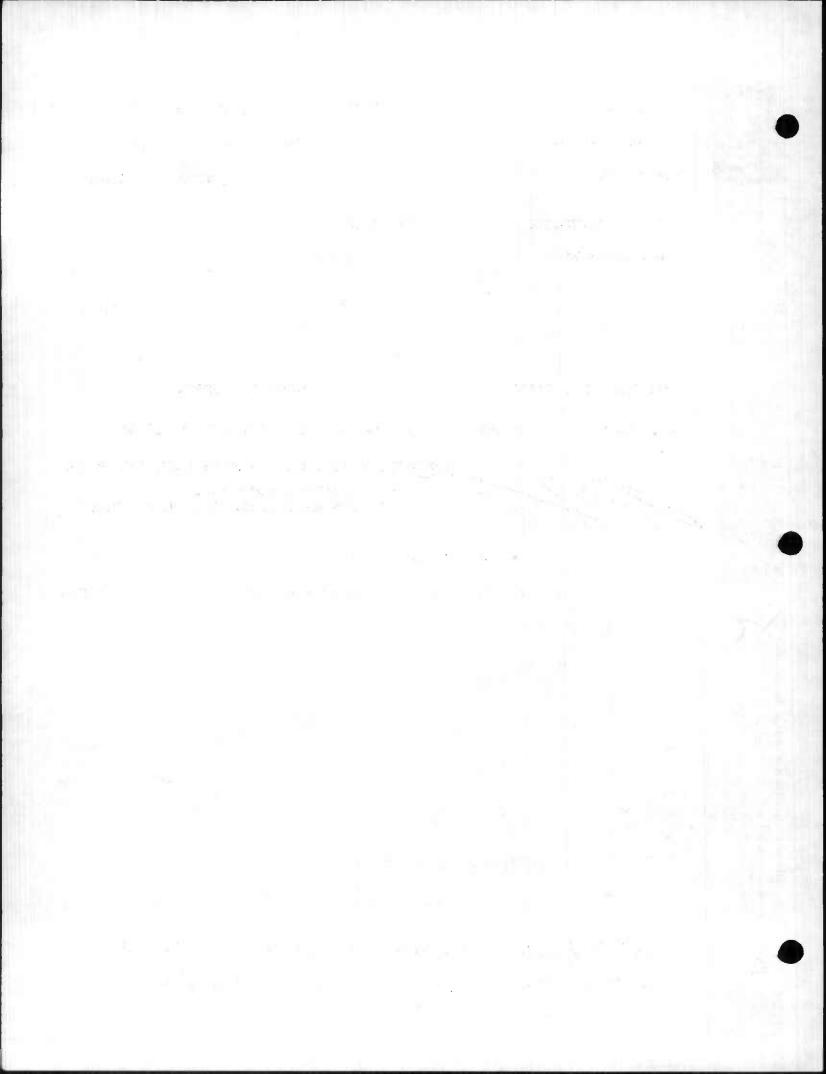
Registrar **DHMH 16 Rev 6/95**

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Johns Hopkins Hosp



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (Eirst, Middle, Last) 2. Dete of Death Month ennin **Physician** e5.5e 14, July 1998 11:41 AM /Medical 45. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Carroll County Hospital Carroll County Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Montha Days Hours Min. (Month, Dey, Year)
July 5, 1920 Virginia 6. Sex **X**OM 2□ F 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 78 Yrs. 216-16-9071 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show eny Injury or other traumstic event, the Nexice Example matter matter. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Director Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 319 Royer Road 21158 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Meritel Stetus Black, White, etc. X Yes 2 No If Yes, Give Year or Dates: 1 Never Merried XX Married altimore, Maryland 21215-0020 1 Yes 2X XIo Specify: Specify: þ white 3 ☐ Widowed 4 ☐ Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Montgomery County Elementery/Secondary (0-12) College (1-4or 5+) Police Dept. Police Officer 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jesse M. Jennings Nellie H. Hubbell 19a. Informent'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 319 Royer Road Westminster, MD 21158 of Disposition (Name of Date 20c. Location - City or Town, State Germaine Jennings Wife 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 1X Buriel 2 Cremation 3 Removal from State Dulaney Valley Mem. 7/17 Cockeysville, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Burgee-Henss Funeral Home, P.A. 3631 Falls Road Baltimore, MD 21211 me deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Betw Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as e consequenca of) Division of Vital Records, P.O. Box Part II. Other algorificant conditions contributing to death but most resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Completed certificate has b lirector, page 2 sl 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No r death. 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 hours after unerel Direc 4 Homicide Hospital 24 hours 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and menner es steled.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edical (Check only 29b. Signature and title of certifier

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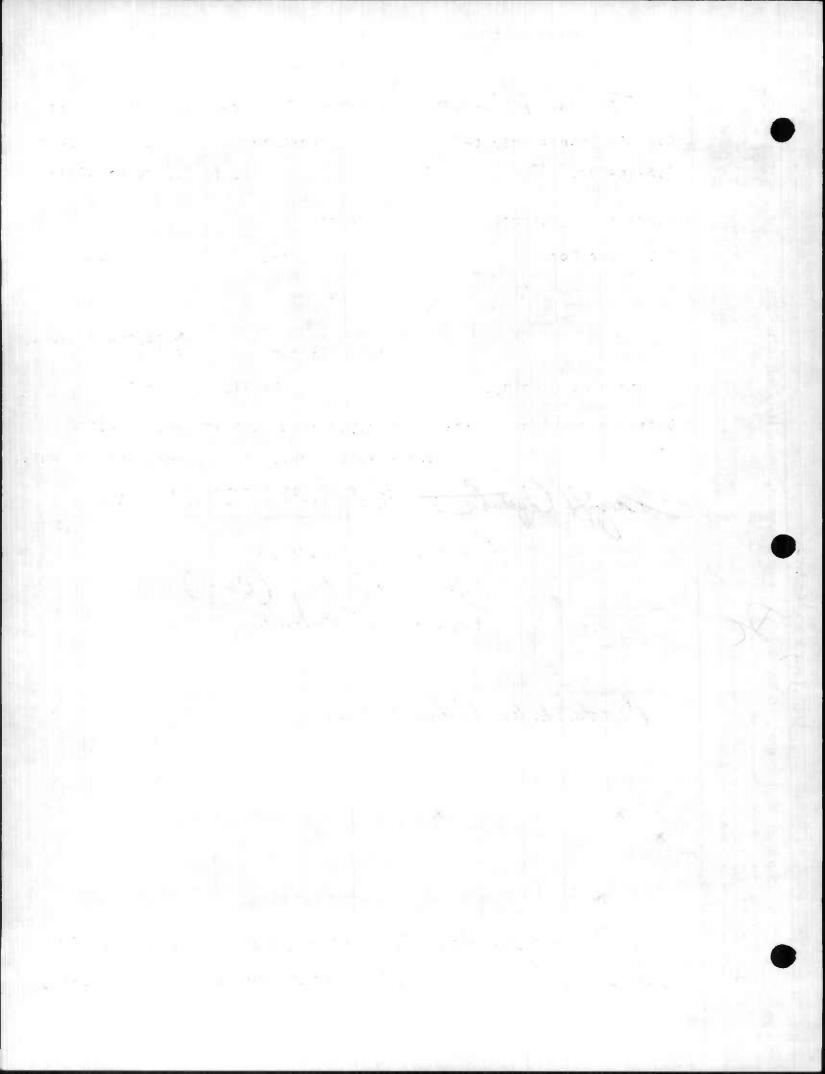
State Registrar 31. Dete filed (Month, Day, Year) 32. F

and address of person

nytho completed cause of deeth (Itam 23e) (Type, Print) Le L. Westminster MD.

1) 32. Registing Standard Rendelle

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LS.	E JOHNSON	N PART I, II, 27 PER G761	State of Maryland	-	nt of Health and te of Death		giene 98	21825
	Physician	1. Decedent's Name (First, Middle, Last				2. Dete of Dee Month JULY	eth Day	Yeer 3. Time of Death
	' /Medical Examiner	4a Fecility Name (If not institution, give 608 WHITMORE AVEN	street and number)		4b. City, Town	, or Location of Death		
	Funeral Director	210-42-1900	7. Age (In yrs. Ia.	yrs. If Unde Months	r 1 Year if Under 24 Days Hours	Hrs. 8. Dete of Birt (Month, De)	v. Year)	Birthplace (State or Foreign Country) MD
	a-f show	Usual Residence of Decedent 10a. State 10b. County MD NA		Town or Location				t0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the Me. 23a or 28a-fa at be notified	10e. Street and Number 608 WHITMORE	AUENUE	10f. Zi	21216		10g. Citizen of W	hat Country? JSA
020	72 hours efter deeth with the Meryland natural; or Items 23a or 28a-f ahow final Examiner must be notified at ested by Funeral Director	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Dece If Yes, spe	dent of Hispanic Origin city Cuban, Mexicen, F 2 P No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Rece Black Specify:	- Americen Indian, k, White, etc.
21215-0020	ed within 72 hours ygiene. nor than "natural", it, the Medical Exe Completed by	15. Decedent's Edu (Specify only highest gred	completed)	16e. Decedent's Usu (Give kind of we life. DO NOT U	ork done during most of ise retired)	f working	16b. Kind of But	
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	of Haalth ar of Haalth ar f from 27 is r other trau	19e. Informant's Name/Relationship (7) HENRY LEE JOHN 20a. Method of Disposition 1 Burial 2 Cremation 3 F	SON HUSBAND 20b. Pie	608 WHIT	S (Street end Number of MORE AU) me of other plece)	E BALTO Date	. MD.	State, Zip Code) 21216 City or Town, State
Baltimore,	Department Department Important: h any injury o once.	4 Donetion 5 Other (Specify) 21. Signature of Funetal Service License	And	VAUGH	ALTO MATI	DIVE BAL	DALTO. RAL SER 10. MD.	NICE 21229
	Physician /Medical Examiner	resulting in death)	CARDIAC HYPERT			rdiac or respiratory an	rest,	Approximate Intervel Between Onset and Death
0/	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Due to (or a	as a consequence of)				
Box 6876	death cent rate by a stending privile by d for use as the busine by it clan/Medical	that initiated events resulting in death) Last	Due to (or a	as a consequence of)				
P.O.	d by the detached	Part II. Other significant conditions con	ntributing to death but not result		ceuse given in Part I.		tobacco uae con Yee 2 No	tribute to the cause of deeth?
Records,	been sign should be					24a. Was perio	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Re	certificate has rector, page 2	25. Was case referred to medical			26. Place o	of Deeth (Check only o		1 Yes 2□ No
Division of Vi	ding Phys h. After this funeral di	exeminer? 1	28a. Date of Injury (Month, Day Year)	М	OA Other: 4 Nurs 28c. Injury at Work? 1 Yes 2 No	ing Home 5 餐 Resident	dence 6 D0the	ed
Divi	Hospital or Attant 24 hours efter deat Funeral Director: stely filled in by the Jical Certifical	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)			City or Tox	vn, Stete)	er or Rural Route Number,
	a planting		ner: On the basts of exeminetic and manner stated.	on end/or investigetion		occurred at the time,	date end plece, a	
	Townson Townson	Denning.	Chute no		O.C.M.E.		JULY 15	, 1998
	6	D TUNI	ompleted cause of death (Item 2 te M) 32. Regions 5 1001	111 Penr	Street, E	Baltimore,	Marylan	d 21201
	State Registrar	JUL 16 19	38 Julia Day	idson-Randel	2			

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Nama /First Middle Last 2. Dala of Daath Month TICHAEL TARRET 4b. City, Town, or Location of Death 4c. County of Death Salt more 5. Social Security Number if Undar 24 Hrs. 8. If Undar 1 Yaar 7. Aga (In yrs. last birthdey) 9. Birthplaca (Stata or Foreign 212-53-7854 Yrs Usual Residence of Decadent 10a. Stata 10b. County 10d. Inside City Limits MD N/A BALTIMORE CITY YYes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? U.S.A 26 NORTH KENWOOD AVENUE 21224 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Guban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Marriad 1□ Yes 2 No Specity: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Spacify only highest greda completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry N/A Elemantary/Secondary (0-12) College (1-4or 5+) None 17. Fathar's Name (First, Middle, Lest) 18. Mother's Nama (First, Middla, Maiden Sumeme) MICHAEL JARRETT TINIKA SWANN 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL JARRETT/FATHER 26 NORTH KENWOOD AVENUE BALTIMORE, MARYLAND 21224 20b. Placa of Disposition (Nema of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from State HOLLY HILL CEMETERY 7/15/98 MIDDLE RIVER, MARYLAND 21. Signatury of Funaral Service Licenses 22. Name and Addrass of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224 234 Partt. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown of heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Enterobacter Meningitis and Sepsis Immediate Cause (Finel diseasa or condition resulting in death) lebsiella Sequantially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disaasa or Injury that Initiated events rasulting in death) Lasl Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No 24a. Was an autopsy performed? 24b. Wara autopsy findings 1 ☐ Yes 2 ☐ No

Amanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. attending physiclan

Examiner Physician/Medical à Completed Be To

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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traumatic avent, the Medical Examiner must be notified at

pemil. Pages 1 and 2 should be filed within 72 hours effer death v Department of Health and Menial Hygiene. Important: If Item 27 is marked other than 'natural', or items 23a eny Injury or other traumatic avent, the Madical Essential States.

Physician /Medical

Examiner

21215-0020

Baltimore, Maryland

Completed by Funeral Director

Be

the Maryland

Certification: within 24 hour Medical

25.

27

4 - Homicide

29a. Certifier

29b. Signature

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Wes casa raferred to medical examiner? 1 Yas 2 No							28	Place of De	ath (C	hack only one
		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA					Other: 4 Nursing Homa 5 Res			
Manner of Death 1 Natural 2 Accident	5 Panding investigation	(A	ate of Injury Month, Dey Year)	28b. Time of injury	М	28c.	injury at Work? 1 Tyes	2 🗆 No		. Describe ho
3 Suicide	6 Could not be	28e. Pi	lace of Injury - At h	ome, farm, siree	t, fact	ory, of	fice		28f.	Location (Str

n	28a. Date of Injury (Month, Dey Year)	28b. Time of injury	28c. injury at Work?		28d. Describe how injury occurred
0	28e. Place of Injury - At h building, etc. (Specia	ome, farm, street, fac fy)	tory, office		28f. Location (Street end Number or Rural Route Number, City or Town, Stete)
ys	clan: To the best of my kno	owledge, death occurr	ed at tha tima, o	lata and place	a, and due to the causa(s) and manner as atated.

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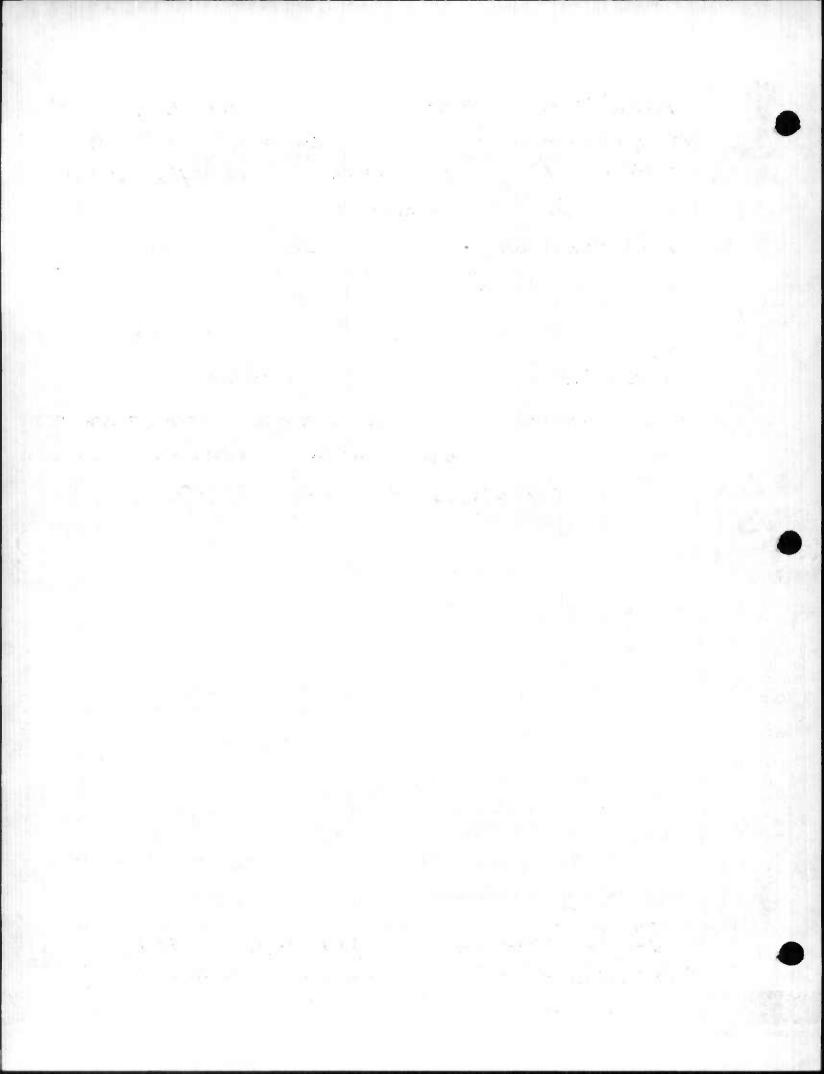
Certifying F 2 ☐ Medical Exp	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, death occurred at tha tima, data and placa, and tion and/or investigation, in my opinion, daath occurred a	due to the causa(s) and manner as atated. It the time, date end place, and dua to the cause(s
and title glycertitier	1.1	29c. Licanse number	29d. Data signed (Month, Day, Year)

l		/	77.45	1	ナント	00	7/61	179	
	30. Nama and address	ss of person who complated of DULKERIAN	causa of daath (Item 23a) (Type, Print), MD., Herry Leduca	e Center	301	ST PAN	· PLACE;	BALTIMERE +	10

31. Date filed (Month, Day, Year) State Registrar



DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 2. Data of Death 3. Time of Death 1 Decedant's Nama (First Middle Last) **Physician** 0430 JONFR JULY UANITA /Medical 4a Facility Name (If not Institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANDALLS TOWN HOSPITAL BACOMORE CENTTER VONTHWEST if Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, 5. Social Sacurity Number If Undar 1 9. Birthplaca (Stata or Foraign 7. Aga (In yrs. last birthday) **Funeral** BALTIMORE, MD. 1□M 2**X**)F Months Days Yrs. 72 DEC 2,1925 215-22-8523 Director Usual Rasidance of Decedant with the Marylend r 28a-f show 10a Stata 10b. County 10c. City. Town or Location 10d. inslda City Limits 1X Yes 2 No BALTIMORE Directo MARYLAND 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 1 any injury or other traumatic event, the Medical Examinet must be in once. 7127 ROLLING BEND RD. APT F 21207 USA Funerai 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No Specify: altimore, Maryland 21215-0020 Specify: AFRO. AMERICAN by 3X Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highest grade complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 18b. Kind of Business/industry Elamantary/Secondary (0-12) Collega (1-4or 5+) SOCIAL SECURITY ADMIN. SECURITY GUARD 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be LYDIA JONES **ELMER** BOWIE 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. informant's Name/Ralationship (Type, Print) 7127 ROLLING BEND ROAD, BALTIMORE, MARYLAND 21207 WILLIAM TURNER SON 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State METRO CREMATORY, INC. 7/16/98 CATONSVILLE, MD. 4 Donation 5 Othar (Specify) 22. Nama and Addrass of Facility
ESTEP BROTHERS FUNERAL SER, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 Approximata interval Batween Onset and Daath 23a. Part 1. Enter the disease or complications that cause of the cause of the cause of dying, such as cardiac or raspiratory arrest, shock, or have failure. List only one cause on each line. Physician Immediata Causa (Final disaasa or condition rasulting In daath) /Medical SEPSIS **Examiner** Dua to (or as a consequence of) Physician/Medical Examiner -OBSTRUCTIVE NEUMONIA Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated evants rasulting in death) Last Syvamous Division of Vital Records, P.O. Box 68760, 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown The law requires that EHY MATION þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed OBSTRUCTIVE PULMONARY DISENSE has is certificate ha 2 18 No 20 No Physician; 25. Was casa rafarrad to madical examinar? Be 26. Placa of Daath (Chack only ona) 1 Yas No Hospital: Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1. Impatiant 2 ER/Outpatient 3 DOA 10 this funerai 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification: i or Attanding Fafter death. After 1 Matural 5 Panding invastigation 1 Yas 2 No Diractor: A 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datarmined 3 Suicide 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicida 24 hours after Funeral Dira letely filled in b Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exampler: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Cartifian edicai iner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. Licensa number 29d. Pata signed (Month, Day, Year) 29b. Signature and titla of certifie 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) CENTER CAMIZA NONTHWEST

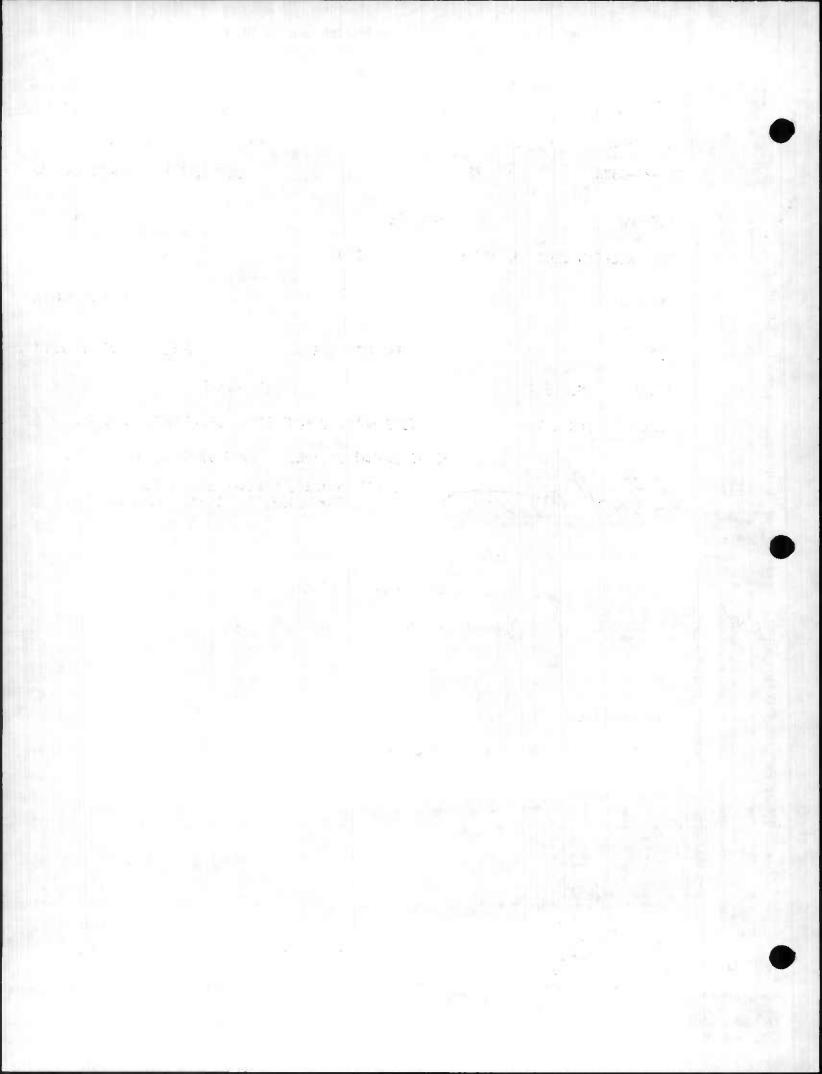
State Registrar

31. Data filed (Month, Day, Year)

JUL 161998

32. Regist

rina Davidson



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State of Maryland / Department of Health and Mental Hygiene Q 8 2 1 0 2 0

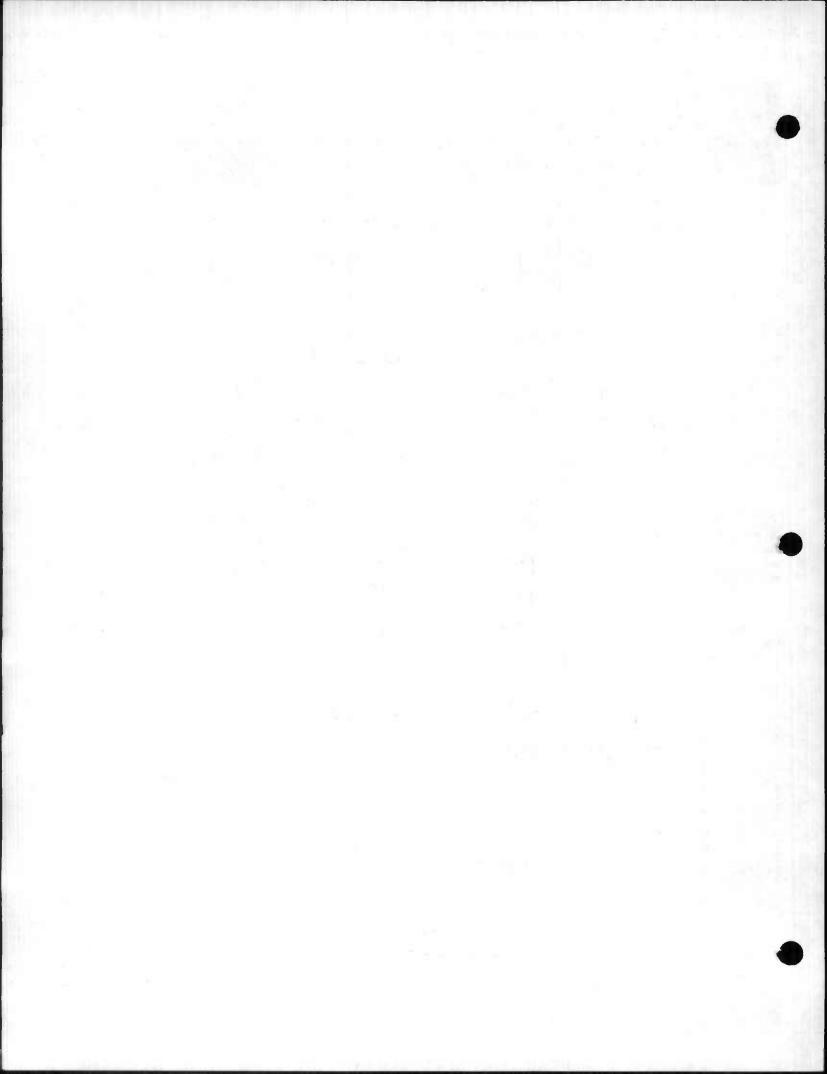
			C	ertificate of	Death		Reg. No.	0 21028	
	1. Decedent's Name (First, Middle, Li	est)				2. Dete of D Month	eeth Dev	3. Time of Deeth	
hysician /Medical	Samuel		Jon	es			Eighth 1	998 Four Farry two	
xaminer	4a Facility Name (If not institution, gir	re street and number)	1		4b. City, Town, or			100	
	Johns Hopki	nstospita	Ч	-	BaHimor-	_	00-	more Coty	
al or		Sex 7. Age (II 1 → M 2 □ F 57	n yrs. lest birtho Yn	Months Days	Hours Min	8. Dete of B (Month, D	irth (Pear) 1940	Birthplace (State or Foreign Country) unknown	
	Usuel Residence of Decedent							1011 11 00 11 0	
_	10a. Stete 10b. County		c. City, Town o					10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
Director		ore City	Baltimo						
ai Dir	10a. Street and Number 1046 North Poi	nt Road		10f. Zlp Coda 21224			U.S.A.	Α.	
Funeral	11. Mentel Stetus	12. Wes Decedent Eve Armed Forces un	in U.S.	13. Wes Decedent of I If Yes, specify Cub	Hispenic Orlgin? (S	Specify Yes or N	lo- 14. Raci	a - American Indian, k, White, etc.	
þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:		1□ Yes 2⊠ No				Black	
Completed	15. Decedent's E (Specify only highest gr		16a. D	ecedent's Usuel Occup	petion during most of we	rkina	16b. Kind of Business/Industr		
pje	Eiemantery/Secondary (0-12)	College (1-4or 5+)	'li	Rive kind of work done to the DO NOT use retire	daming most of the				
Con	unknown	unknown	un	known			unknow		
Be	17. Fether's Neme (First, Middle, Las				18. Mother's Name (First, Middle, Meiden Sumame) Rosetta Barber				
9	Samuel H. Jones	, Sr.			Kosett	a Barber			
	19e. Informent's Neme/Reletionship			19b. Mailing Address (Street and Number or Rural unknown			ber, City or Town,	State, Zip Code)	
	Arlene Campell/						,		
	20e. Method of Disposition 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ 4 ☐ Connection 5 ☐ Other (Speci	Removel from State	20b. Placa of D cematery,	isposition (Name of cremetory or other ple	ca)	Deta	20c. Location -	City or Town, Stete	
	21. Signature of Fundal Service Lice Ronal d		ctor		_			imore Street	
State Anatomy Board, 655 W. Baltimore Baltimore, Maryland 21201 23a. PMI. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.									
	Immediate Ceuse (Finel disease or central on a Possible Pulmonary Embolism								
	diseese or condition resulting in death)				polism			five minutes	
Per			e to (or es e co	rsequence or):				les vert	
Examiner	Convention had conditions	b. immob	to (or es e coi	sequence of):				Herr Years	
Exa	Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Diseese or Injury	1011-1	1 4-	1				10000000	
edical	that initiated evants	C. DI INTORCI	to (or es e cor	knee av	vopo (t. d. t.))		14.700.3	
2 g	resulting in deeth) Lest	Derinhan	I doc.	lar Diseas	. 6			twenty years	
by Physician/M		d. Peripher	1 Verse	191 VISEU	20			Twent / Teens	
Sicia	Pert II. Other significant conditions	contributing to death but n	ot resulting in the	ne underlying cause gi	ven in Part I.	23b. Die	d tobacco use co	ntributa to the cause of death	
hy	T-1 (1)	113				10	Yee 2□ No	3 Probably 4 Unknow	
by	and stage le	nal disease							
9						24e. Wa	s an autopsy formed?	24b. Wera autopsy findings avellable prior to	
pie								completion of cause of daath?	
Completed						1	Yes 2 No	1 ☐ Yes 2 ☒ No	
Be C	25. Was casa raferred to medical				26. Plece of De	eth (Check only	(ona)	1000	
ToB	examiner? 1 ☐ Yes 2 ☒ No	Hospitel: 1 Inpatient	2□ ER/Outp	atient 3 DOA Ot	hor		sidence 6 □Oth	er (Specify)	
	27. Manner of Death	28e. Dete of Injury (Month, Dey Yo		ne of 28c. Inju		_	e how Injury occur		
tio	1 Naturel 5 ☐ Pending 2 ☐ Accident investigation		9 <i>ar)</i> Inju		ork?]Yas 2□No				
ertifica	3 Sulcide 6 Could not to determined	28a. Place of Injury building, etc. (5	- At home, fam Specify)	, street, factory, offica		28f. Location City or T	(Street and Numb own, State)	per or Rural Routa Number,	
edicai Certification:	(Check only 2 Medical Exa	nysician: To the best of miner: On the bests of ex	amination end/d						
Med	one) 29b. Signature and little of certifier	and menner stated		29c. Licen	sa number		29d Date sione	d (Month, Day, Year)	
	250. Signature and Conjun	mo							
	A- Level Bu	in		KES	-000		July Eigh	th 1998	
	30. Neme and address of person who	1 11 11	n (Item 23a) (Ty	rpe, Print)	11 , 11	c. 0		WD 31202	
	G. Keith Bruce ME	Johns Hept		pital 601	M. Wolf	e >+ K	altimore	W/> 71707	
ate	31. Dete filed (Month, Dey, Year)	32. Registrar's	Signeture						
strar	OUL 1619	98 Julia	Davidson	Bodes					
6/95		U		1					

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State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.	18 21829
Dhuais	lan	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	3. Time of Death
Physic /Med		Ronald Joyner	July 15 1	998 12:45 AM
Exami	ner	4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Low	cation of Death 4c. Count	y of Death
		Johns Honkins Geniatrics Center Baltim 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) If Under 1 Year If Undar 24 Hrs.	8. Date of Birth	a Bighologo (State of Estate)
Funeral Director		217-04-9733 1XM 2 F 32 Yrs. Months Days Hours Min.	8. Date of Birth Month, Day, Year 966	9. Birthplace (State or Foreign Mountry)
yland how		10a. Stata 10b. County 10c. City, Town or Location		10d. Inside City Limits
e Ma	ctor	Maryland N/A Baltimore		1) Yes 2□No
d 21215-0020 filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or items 23a or 28a-f show ont, the Wedical Exemple Inciting at	Funeral Director	2905 Baker St. 21216	10g. Citizen of	What Country?
ter dea	nuel	11. Maritai Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	ecify Yas or No- Rican, etc.) 14. Ra	ce - Amarican Indian, ack, White, etc.
21215-0020 d within 72 hours after giene. or then "netural", or if	þ	1 Nover Married 2 Married 1	Speci	-1
15-0 n 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of worktr iffe. DO NOT use retired)	ing 16b. Kind of E	Business/Industry
d 212 filed within Hygiena. wher then	dmo	Elementary/Secondary (0-12) College/(1-4or 5+)		N/A
and 212 be filed with ital Hygiena. d other than	BeC	17. Father's Nama (First, Middle, Last) 18. Mother's Name	(First, Middle, Meiden Sume	me)
Vian vuid be Mental vrked o	To B	Lerov Joyner Eliz	9 Holr	nes
S me	-	19a. Informant's Name/Relationship (Type, Plint) (Parents) 19b. Mailing Address (Street end Number or Rura	I Route Number, City or Town	, Stete, Zip Code)
₩ ₽ ₽ ₽ ₽ ₽ ₽		Mr.+Mrs. Leroy Joyher 2905 Baker S	t, Balto,1	VId. 21216
Baltimore, semit. Pages 1 at Department of Health mortant: If item in y injury or otherance.		20a. Mathod of Disposition Solution 20b. Place of Disposition (Neme of periodic) 20b. Place of Periodic) 20b. Place of Disposition (Neme of periodic) 20b. Place of Periodic) 20b. Place of Periodic (Neme of periodic) 20b. Place of Periodic) 20b. Place of Periodic (Neme of periodic) 20b. Place of Periodic (Neme of periodic) 20b. Plac	20/98 Lane	- City or Town, State
Baltimol permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Utensee 22. Name and Address of Facility 30 Seph - Ry	ss Funer	
		23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shoot, or hear failure. List only one cause on each line.	r respiratory arrest,	Approximate
Physician		anoly, or near that Chat only one cause or accit line.		Interval Between Onsat and Death
/Medicai Examiner		Immediate Cause (Final disease or condition resulting in deeth) e. pneumonia/sepsis Due to (or as a consequence of):		weeks
- CAGIIIII C	<u></u>	Due to (or as a consequence of):		
cuted od transit	Examine	o pressure ulcers		months
	Exal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or Injury c. Cerebra pals)		
	edical	that initiated events		years
80 X 55	Jed	rasulting in death) Last		
Box eath cer attendir for usa		d		
D. B. a death	sici	Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part i.	23b. Did tobacco usa co	ontributs to the cause of death?
ords, P.O. Box requires that the death censioned by the attendia hould be detached for use	Completed by Physician/	protein energy malnutrition, seizures,	1 □ Yes 2□No	3 Probably 4 Unknown
rds, Pruires that	d b		24a. Was en eutopsy	24b. Were autopsy findinga
lecord	lete	anemia, contractures	performed?	aveileble prior to completion of causa of death?
Il Rec	E		1□ Yes ⊕€No	1 ☐ Yes 2 ☐ No
Vital Indicate rector, pag	Be C	25. Wes case referred to medical 26. Place of Death		1 10 10 10 10
of Vita Physician: this certific al director,	To	examiner? 1 Yes 2 No Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: Wursing Hon	ma 5 ☐ Residenca 6 ☐ Ot	her (Specify)
Vision of Vita Attending Physician: or death. ector: After this certific by the funeral director,		1. Naturel 5 □ Pending (Month, Dey Year) Injury Work?	28d. Describe how injury occu	rred
isio ttendir death. ctor: Al	cati	2 Accident investigation M 1 Yes 2 No		
Division of Vital Records, to Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be a	Certification:	determined determined 4 Homicide 28e. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify)	28f. Location (Street end Num City or Town, Stete)	ber or Rural Route Number,
pital ours ours filled	S S	29a. Certifier Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, e	and due to the cause(s) and m	sannor as stated
Division O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only one) Medical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurre and manner stated.	ed et the time, dete and piaca	, and due to the cause(s)
Division To the Hospital or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	M	29b. Signature and title of centifiar 29c. Licensa number	29d. Date sign	ed (Month, Dey, Year)
^		1/15 RD DO438	3 7/1	5198
		30. Name and address of person who completed muse of death (item 23a) (Type, Print)		Rait, ND
0		W.B. Greenough mo 5505 Hophuns Leg V	lew circle	21274
St Regist		31. Data filed (Month) Day, Year) 32. Paylistrars significant sign		

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				State of M	iaryiar				nealth and Death	o Mentar	Hygie Reg.	9	8 8	21830
Physic	ian	Decedent's Neme (First,	Middle, Las	st)						2. Date Mont	of Deeth	Day	Year _	3. Time of Death
/Medi		Alice		Simpson		irnas				JUL	-4	13 1	1998	4-8m
Exami	ner	4e. Facility Name, (If not ins St. Agnes 5. Social Security Number	11/2	Althcar	e	lest birthday)	If Unde	or 1 Year	8b. City, Town, Balti If Under 24 i	nore		4c. County		less (Chate as Espain)
Funeral Director		231-05-3805 Usuel Residence of Decede	1		81	Yrs.	Months			Ain. (Mon	of Birth th, Day, Ye		Count Ala	lece (Stete or Foreign try) abama
Jand Jand		10e. Stete 10b. C			10c. Ci	ty, Town or Lo	cation						10	0d. Inside City Limits
h the Marylan r 28a-f show	to	Maryland B	altimo	ore		Arbut	us							1 ☐ Yes 2 🛣 No
or 284	irec	10e. Street and Number						p Code			10g.	Citizen of V	What Coun	try?
if wil	alc	1705 Car:	roll A	Avenue				2	1227			П. 9	S.A.	
ter dea	by Funeral Director	11. Maritel Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Div		12. Wes Decedent Armed Forces 1 Tyes 2 1 If Yes, Give Year or Dates:	?		Vas Dece Yes, spe □ Yes		lispanic Origin? an, Mexican, Po Specify:	(Specify Yes uerto Rican, et	or No- c.)	14. Rec	e - America ck, White, o	etc.
c - a	Completed			de completed) College (1-4or	5+)	life. L	kind of wi	ork done use retirad	during most of	working		. Kind of Bu	usiness/ind	dustry
filed within I Hygiene. other than		17. Father's Neme (First, M	iddle. Last)	2		Se	creta	ary	18 Mother's	Neme (First, M				Insurance
d 2 should be filed within the and Mental Hygiene. 7 is merked other than traumetic avent, the Mental traumetic av	To Be			-b Cimpos	_							H i 111	,	
AS DE E	F	19e. Informant's Neme/Rel		h Simpson Type, Print)	1	19b. Meilin	g Addres	s (Street	end Number of				Stete, Zip	Code)
		Mr. Carl Kuri	nas						Avenue			4D 21		
s 1 end 2 st Health ar Hem 27 is other trau		20a. Method of Disposition			1	Place of Dispos	sition (Ne	me of		Date	7	. Location -		wn, Stete
Page ent of mt: If i		1 ⊠ Burial 2 ☐ Crema 4 ☐ Donetion 5 ☐ Oth)				al Park	7/16	S	rkeevi	1116	Maryland
permit. Pages 1 er Department of Hea Important: if item: any injury or othe		21. Signeture of Funerel Se	rvie Lican	m Jer	Ke	22	. Name a	nd Addre	ss of Facility ers Functy Roa				-	
_		255. Part1. Enter the disea	se, or comp	plications that cause	d the deal	th. Do not ente	/ ZO 1 er the mo	Liber de of dylr	ng, such as car	d Rand diac or respiral	ory arrest,	own,	MD :	21133 Approximate
Physician /Medical Examiner		shock, or heart failure Immediate Cause (Finel disease or condition	. List only (2 0		any -	٠.	سىد						Interval Between Onset and Deeth
Examinie	L.	resulting in death)			Due to (or as a conseq	ence at)	li.						6 months
po isi	in e			b. Pul	-	ony	fi	lu					- 1	6 months
	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	{	c		or as a conseq								
death certificate ettending prod for use as	Physician/Med	resoning in death, cast	L	d										
the ett	sici	Part II. Other significant co	nditions co	ontributing to death I	out not res	ulting In the ur	derlying	cause giv	en in Part I.	23b	Did toba	co use co	ntribute to	the cause of death?
d by	by Phy										1 Yes	20 No	3 Prot	pebly 4 ☐ Unknown
requir been s should	Completed									24a.	Was an a performed	utopsy 1?	ave	ere autopsy findings ellable prior to mpletion of cause deeth?
The ate h	Con										1 🗆 Yes	2 No	1 🗆	Yes 2□ No
clan: entific ector,	Be	25. Was case referred to m exeminer?	-							Deeth (Check	only one)			
Physician: Tribis certificat	P	1 Yes 2 No				ER/Outpatien			4 LI IAUISII	g Home 5)
After	Certification:	2 ☐ Accident	ending vestigation ould not be	-		28b. Time of Injury	М		y at k? Yes 2 □ No			njury occur		/ Control Montro
Ital or Al irs efter al Direc	Certif	4 ☐ Homlcide	etermined	building, e	tc. (Specil					City	or Town, S	tete)		I Route Number,
To the Hospital or Attend Within 24 hours effer dealt To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one)	rtifying Phy dical Exam	yalcian: To the best ilner: On the basis of and menner s	of examina	wledge, death tion and/or inv	occurred	et the tir n, in my o	ne, date and pl pinion, death o	ace, and due t occurred at the	o the caus time, date	e(s) and me and placa,	anner as st and due to	eted. the cause(s)
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Sta Regista		31. Dete filed (Month, Day, JUL 1619		2. Regist	widoon	- Gandale								

231-05-3805

Dec. 16, 1916 Alabama

Arbutus Maryland Baltimoree

1705 Carroll Avenue

21227 U.S.A.

White

Prudential Insurance 12 Secretary 2 +

> Elise Epps Hill Charles Kenneth Simpson

1705 Carroll Avaaue Arbutus, MD 21227 Mr. Carl Kurnas

Lake View Memottal Park 7/16 Sykesville, Maryland

plan m ferther Road Randallstown, MD 21133

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Deeth Day Month **Physician** JULY 12, 1998 7:50 PM KRUPNIK /Medical MAYER 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) LEVINDALE NURSING HOME If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex 9. Birthplace State of Sonign **Funeral** 1 ☐ M 2 ☐ F Months Deys Yrs. FEB.23,1933 215-39-1770 65 Director AZERBATJAN Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Y□ Yes 2□ No Director MD N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2434 W. BELVEDERE AVENUE 21215 ISRAEL Funeral Reca - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) WATER & ENVIRONMENT PHYSICIST 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Mentel KRUPNIK BASYA ZEIFMAN **JACOB** 70 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health e Important: If Nem 27 is EUGENE SHLYAK (NEPHEW) 1320 KINGSBURY ROAD OWINGS MILLS, MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriel 2 □ Cremation 3 □ Removal from State ò BALTIMORE HEBREW 7/14/98 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Fundiral Service Licent 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final PROBABLE MYOCARDIAL INFARCTION disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pure Due to (or as a consequenca of): Physician/Medical Due to (or as a consequence of) Se Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 ☐ Unknown POST RIGHT CEREBROVASCULAR Division of Vital Records. by 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Completed NON INSULIN DEPENDENT completion of cause of deeth? DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No To After this 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: or Attending 5 Pending 1 ☐ Yes 2 ☐ No deeth. investigation 2 Accident 24 hours after deet Funerel Director: 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medicai (Check only one) To the Within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier PULLENDING D25610 PHYSICIAN SET HTWAR 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) WEST BELVERDERE AVENUE BALTIMORE MI) LEVINDALE 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Julia Davidan Banda

Registrar

KRUPNIK

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State of Maryland / Department of Health and Mental Hygiene

		Ce	rtificate of De	eath	Reg. No.	0 21832
Physician /Medical	Decedent's Neme (First, Middle, Last) MARY HYL	AN K	eNdrev	U JV	14 10	Yeer 98 3:15 p
Examiner Funeral Director	4e. Fecility Neme (If not institution, give street end number, Charles to wn Care 5. Social Sacurity Numbar 217-44-0789 Usuel Residence of Decedent		If Undar 1 Yaer	Hours Min. (Mor		71 more 9. Birthplece (State or Foraig Country)
Maryland f show led at	10e. Stete 10b. County Maryland Baltimore	10c. City, Town or L				10d. Insida City Llmite
with the Mai 3a or 28a-f s if be notified	10e. Street end Number 709 Maiden Choice Lane	Jacons VI	10f. Zip Code 21228		10g. Citizen of U.S.A.	Whet Country?
should be filed within 72 hours after death with the Maryland nd Mental Hygiana. marked other than "natural", or itams 23e or 28e-f show unatic event, it a Medical Examiner must be notified at To Be Completed by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Armed Forces 1 Yes 2 Miles 1 Yes, Give		Was Decedent of Hispi If Yas, specify Cuban, I 1 ☐ Yes 2 ☑ No	anic Orlgin? (Specify Yas Maxican, Puerto Rican, e Specify:	or No- tc.) 14. Rec Ble Specifi	ce - American Indien, ck, White, etc.
bed within 72 hours bygiana. The transfer in the discala. Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or	5+) (Give	dent's Usuel Occupetto kind of work done duri DO NOT use retired)	ing most of working		usiness/Industry
Nental Hygian Mental Hygian srked other ti artic event, the	12 5+ 17. Fether's Name (First, Middle, Lest) John Perham Hylan	Sc	ocial Worke	r B. Mother's Neme (First, Alice Harr:		
Haelth and N Haelth and M Heem 27 Is mar other traumat	19e. Informent's Neme/Relationship (Type, Print) Charles A. Kendrew/husba 20a. Method of Disposition	nd 709	Maiden Cho	Number or Rural Route Dice Lane, (Catonsville	Stete, Zip Code) , Maryland21228 City or Town, Stete
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haelth and Mental Hygiana. Important: if Item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner man be notified at once. To Be Completed by Funeral Director	1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 21. Signeture of Funerel Service Licenses Ronald 5. Wade	Director S				imore Street
Physician	23e. hartt. Enter the disease, or complications that cause hock, or heart feilure. List only one ceuse on each	d the death. Do not en		Maryland 21 such as cardiac or respire		Approximata tritervel Between Onset end Deeth
/Medical Examiner ট	Immediate Cause (Final disease or condition resulting In deeth)	UVOSEPS Due to (or es conse	Quence of):			Day5
icate be executed physician and is the burial-transit	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury C.	Due to (or es e conse	quence of):			
nding physicus as that use as the track.	thet initieted events resulting in deeth) Lest	Due to (or as e conse	quence of):			
as that the death cer igned by the attendir be detached for usa by Physician/h	Part II. Other significant conditions contributing to death to Advance Device to			In Part I. 23	b. Did tobacco use co	ontribute to the cause of death
Hospital or Attending Physicien: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicia ataly filled in by the funeral director, page 2 should be detached for use as the burdleal filled in by the funeral director, page 2 should be detached for use as the burdleal filed. To Be Completed by Physician/Medical	Advance Demento Anemia of chr	onic De	sease	246	. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
Physicien: The this cardificate ral director, page Co.	25. Wes case referred to medical exeminer?		Other	8. Plece of Deeth (Check		1 ☐ Yes 2 ☐ No
Attending Physic in death. actor: After this ciby the funeral direction: To	1 Yes 2 Vo 10 10 10 10 10 10 10 10 10 10 10 10 10	ent 2 ER/Outpatie ury 28b. Time of lnjury	of 28c. Injury et Work?		Rasidence 8 Oth scribe how injury occur	
Lal or Attending P rs after death. In Director: After t ed in by the funer Certification:	3 ☐ Sulcide 6 ☐ Could not be 28e. Plece of in	jury - At home, ferm, st tc. (Specify)	treet, factory, office		ation (Street end Numb or Town, Stete)	ber or Rurel Route Number,
Hospital 24 hours a Funeral C plataly filled	29e. Cartifler (Check only one) 17 Certifying Physician: To the best 2 Medical Examiner: On the basis on end menner standard	of examinetion end/or in				

State Registrar 29b. Signeture and title of cartifiar

Andres Salazar

31. Dete filed (Month, Dey, Year)

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Lane, catonsville, MP, 21228

a solve or a solve of 200 m

Physician
/Medical
Examiner
Examiner

Funeral

Director

pempli. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 23s-f show any Injury or other traumatic event, me Wedies Esserines mail be notified as

Physician /Medical

Examiner

ettending physician and

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certificate

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in 24 hours after deam.
The Funeral Director: After the

within 2 \$

Hospital

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funeral director,

The law requires that the death certificate be again

P.O. Box 68760,

Records,

Division of Vital or Attending Physician:

Baltimore, Maryland 21215-0020

4a Facility Neme (If not institution, give street and number)

Joseph

1. Decedent's Neme (First, Middle, Last)

28 North Lakewood Avenue 5. Social Security Number

6 Say 100 M 2□ F

Baltimore City If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Months Deys

4b. City, Town, or Location of Death

Birthplaca (State or Foreign Country)

12:46 P.M.

10d. Inside City Limits

218-22-6988 Usual Residence of Decedent 10a State

10b County N/A 10c City Town or Location Baltimore

Yrs.

Kaczmarek

70

1 ♥ Yes 2 No

July 25, 1927 Maryland

4c. County of Death

10e. Street end Number

Md.

Director

Funeral

þ

Completed

10

Examiner

Physician/Medicai

λq

Completed

Be

Certification: To

edical

28 N. Lakewood Avenue

21224

10f Zin Code

10g Citizen of What Country? U.S.A.

11. Marital Status 1 Never Married 2 Married 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 XNo It Yes, Give

13. Wes Decedent of Hispanic Origin? (Specify Yes or Notit Yas, specify Cuben, Mexican, Puerto Ricen, etc.) 1 Yes 2 No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

12 17. Fathar's Nema (First, Middle, Last)

3 XWidowed 4 ☐ Divorced

Joseph Kaczmarek

18. Mother's Neme (First, Middla, Maiden Sumame)

July 8, 1998

Lillian Cieslienski

19e. Intorment's Name/Relationship (Type, Print) Gerald M. Kaczmarek /Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 S. Kenwood Ave., Balto., Md. 21224

20e. Mathod of Disposition 1 ☑ Buriel 2 ☐ Crametion 3 ☐ Removet from State 20b. Plece of Disposition (Name of cemetary, crematory or other place)

Policeman

20c. Location - City or Town, Stata Dete

Law Enforcement

4 ☐ Donetion 5 ☐ Other (Specify)

St. Stanislaus Cemt. 22 Name and Address of Facility

7-11-98 Balto., Md.

21. Signerum of Funerel Service Licensee Homas uanita ()

Moran-Ashton-Dabrowski-Matthews Funeral Home 3000 East Baltimore Street, Baltimore, Md. 21224 Inter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, in heer feilure. List only one cause on each line. Approximete Intervel Between Onsat and Death

Immediate Causa (Final diseese or condition resulting in deeth)

· Myocardial Infarction

minutes

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest

fibrillation

Hypertension

Dua to (or as a consequence of): HOL

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Arthritis

Hiatal horria

24e. Wes en eutopsy performed?

1 Yes 2 No

24b. Were eutopsy findings available prior to completion of cause of deeth?

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - Al home, farm, street, factory, office building, etc. (Specify)

26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Baltimore Ms

1 ☐ Yes 2 ☐ No

25. Was case reterred to medical exeminer?
12 Yes 2 No

27. Menner of Deeth 1 Naturet 2 Accident

5 Pending Investigation 6 Could not be determined 28e. Dete of Injury (Month, Day Year)

28b. Tima of

28c. tnjury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

29a. Certifier (Check only one) Lactifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the tima, date and place, and due to the cause(s) and manner stated.

29b. Signetura and title of certifier .

3 Sulcide

4 ☐ Homicide

29c. License number

29d. Date signed (Month, Day, Year) 8

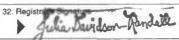
28f. Location (Street and Number or Rural Route Number, City or Town, State)

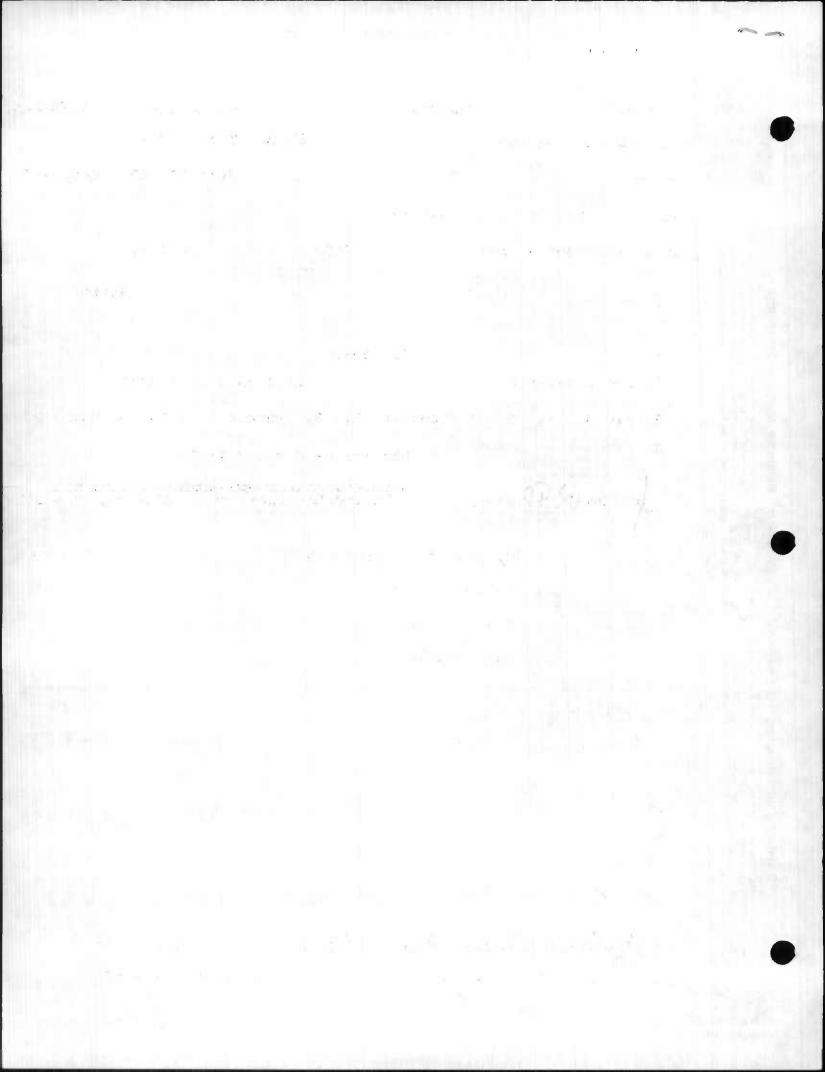
30. Neme end eddress of person who completed cause ot deeth (Item 23e) (Type, Print)

Linder Stephanie 31. Dete tiled (Month, Day, Year)

2801 Foster Ave

State Registrar





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Neme (First Middle Last) 2. Date of Death Day July 13, 1998 2:15p.m. Andrew Lapaglia Anthony 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death 8410 Maymeadow Court Randallstown Baltimore If Undar 24 Hrs. Hours Min. If Under 1 Year 6. Sex 1 M 2 F Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 71 Yrs. Dec. 22,1927 Maryland 220-12-2818 Usual Residence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8410 Maymeadow Court 21244 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ₭ Yas 2 □ No if Yes, Give Year or Datas: 1950 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Flementery/Secondery (0-12) College (1-4or 5+) 8th Grade Steel Worker Bethlehem Steel Corp. 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) Thomas LaPaglia Tullia Gallucci 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Mary A. LaPaglia 8410 Maymeadow Court; Randallstown, Md. 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park7/15/98 Sykesville, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Loring Byers Funeral Directors 8728 Liberty Road; Randallstown, Md. 21133 H the death. Do not antar the mode of dying, such as cardiac or respiratory errest, 23a. Pa t1. Er er the diseasa, or complications that caused in ship of heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · CONGESTIVE HEART FAILURE Sequentially list conditions, if any, laeding to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TO Yes 2 No 3 Probably 4 Unknown ANEMIA GAMMOPAT (P) performed? 24b. Were autopsy findings available prior to MMUHOGLOBULIN M completion of causa of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Naturel 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier

Examiner Records, The law Division of Vital

Physician

/Medical

Examiner

Director

Funerai

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Completed

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or any injury or other traumatic avent, Ita Mades Examinations.

Physician

/Medical

Examiner

Physician/Medicai

by

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To

Certification:

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(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

USB

signed by the a d be detached f

i certificate hes b

funeral

completely

Baltimore, Maryland 21215-0020

or Attending Physician: after death. Director: After this certifica A 24 hour. the Funeral Directified in Hospital To the Vithin 2

State Registrar

JUL 16 1998

-col

29c. License number

29d, Date signed (Month, Day, Year)

WESTMINSTER

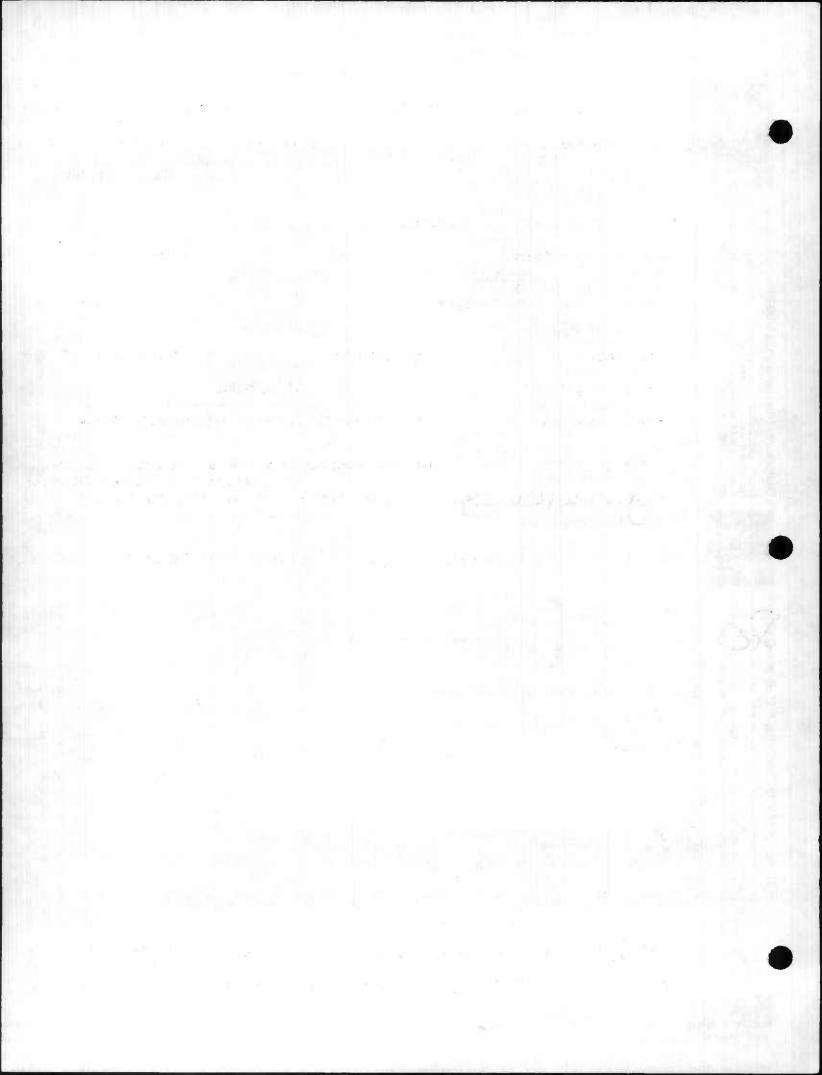
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30. Name and addrass of berson who completed cause of death (Item 23a) (Type, Print)

MAI SYED 412

32. Registrar's Signature who Davidson- Mandale

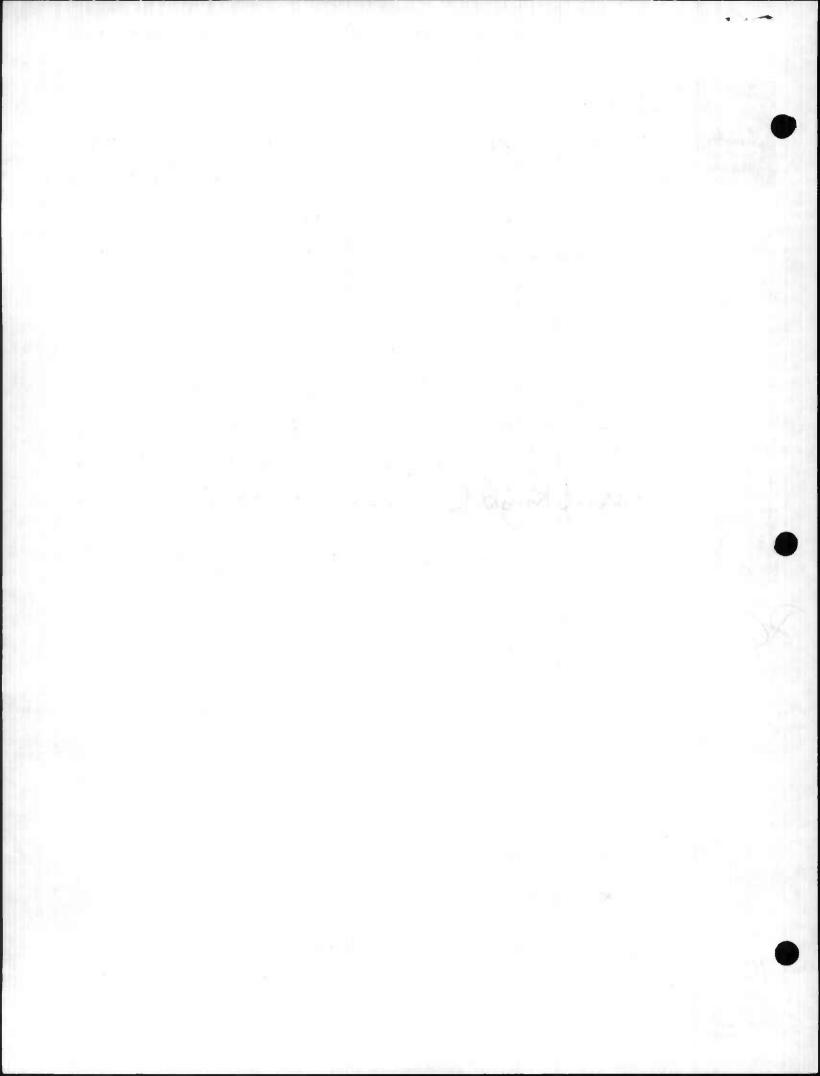
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				Certifica	te of Death	F	Reg. No.	Co.	000
Physicia	30	1. Decedent's Name (First, Middle				2. Date of Dea		Yeer 3.	Time of Death
/Medic	_	Clinton 1	N. Langlois	\$		7	15		2:10 AW
Examin	er	4e. Fecility Name (If not institution			4b. City, Town, or I				
		8C Glenshar		forther by Killade	ESSE or 1 Year if Under 24 Hrs.	X		altimor	
Funeral Director		5. Social Security Number 123-24-3913 Usual Residence of Decedent	6. Sex 1 □ M 2 □ F 7. Age (In yrs	Months		8. Date of Birt (Month, Day Feb. 3	1932	9. Birthplece Country) Westvil	(State or Foreign
and war		10a. Stete 10b. County	10c. C	ity, Town or Location				10d, I	nside City Limits
the Merylan 28a-f show	Director		altimore		Essex				I□Yes 2∏(No
23a or 2	rai Dir	10e. Street and Number 8 C G1 e	enshannon Court	10f. Zi	21221		Og. Citizen of V United	What Country? States	3
	by Funeral	11. Maritel Stetus 1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in It Armed Forces? 1 ⊠ Yes 2 □ No 19 If Yes, Give Year or Dates: 19	52 1 Vac	odent of Hispanic Origin? (Secify Cuban, Mexican, Puert 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Rec Blac Specify	e - American Ir k, White, etc.	nite
natural',	etec	15. Decedent (Specify only highes	's Education	16a. Decedent's Usu	iel Occupation	kina	16b. Kind of Bu	siness/Industr	у
than than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Machinis	ork done during most of wor use retired) †.	Kii iy	Aircraf	t. Produ	uction
エカミ	Be C	17. Father's Name (First, Middle,	Last)	Hachinis	18. Mother's Nan	ne (First, Middle,		-	dcolon
905	To B		Warren Lang	lois	Euni	ice Jone	S	,	
PEE	-	19a. tnformant's Name/Relations			s (Street and Number or Ru			State, Zip Coo	(e)
alth er 27 Is or trau		Helen L. Langlo	is (Wife)		shannon Court				
t He mother		20a. Method of Disposition	20b.	Piece of Disposition (Na cemetery, crematory or	me of	Dete	20c. Location -	City or Town,	State
		1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (Sc	3 Li Removal from State	lltop Servi		/18/98	Towso	n Mary	land
Department of Her mportant: If Item any Injury or othe ance.	-	21. Signature of Funeral Service		ght Jr 22. Name a				-	24114
Impo any tr		> mift	KAA		L	eonardJ.			
	\dashv	23a. Part 1. Enter the disease, of	complications that caused he des	oth. Do not enter the mo	larford Road E	or respiretory ar	e, Maryı		214 proximate
ysician	1	shock, or heart failure. List	only one cause on each line.					tnte	rval Between set and Deeth
Medical	н	Immediate Cause (Final	Makashal	in Non Co	11 (01)	C	211666	2	- years
xaminer		disease or condition resulting in death)	a Metastat	or as a consequence of	Nall Cell F	ung	INCEL		70013
	Je		200 10 (or as a consequence or,	•	V		1	
bunal-trensit	Examiner	Sequentially list conditions.	b. Due to (or es a consequence of)	:				
- Jan		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury							
the bi	0	that initiated events resulting in deeth) Last	CDue to (or as e consequenca of)	:				
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or us	2							i	
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per per	sicia	Part II. Other significant conditio	dne contributing to death but not re-	sulting In the underlying	cause given In Part I.	23b. Did t	obacco use cor	ntribute to the	cause of death?
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gned by be detec	by	Part II. Other significant conditio		sulting In the underlying	cause given In Part I.				
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been s should	by	Part II. Other significant conditio		sulting In the underlying	cause given In Part I.	1, 27	7ee 2□ No en autopsy	3 Probably 24b. Were a	utopsy findings le prior to tion of cause
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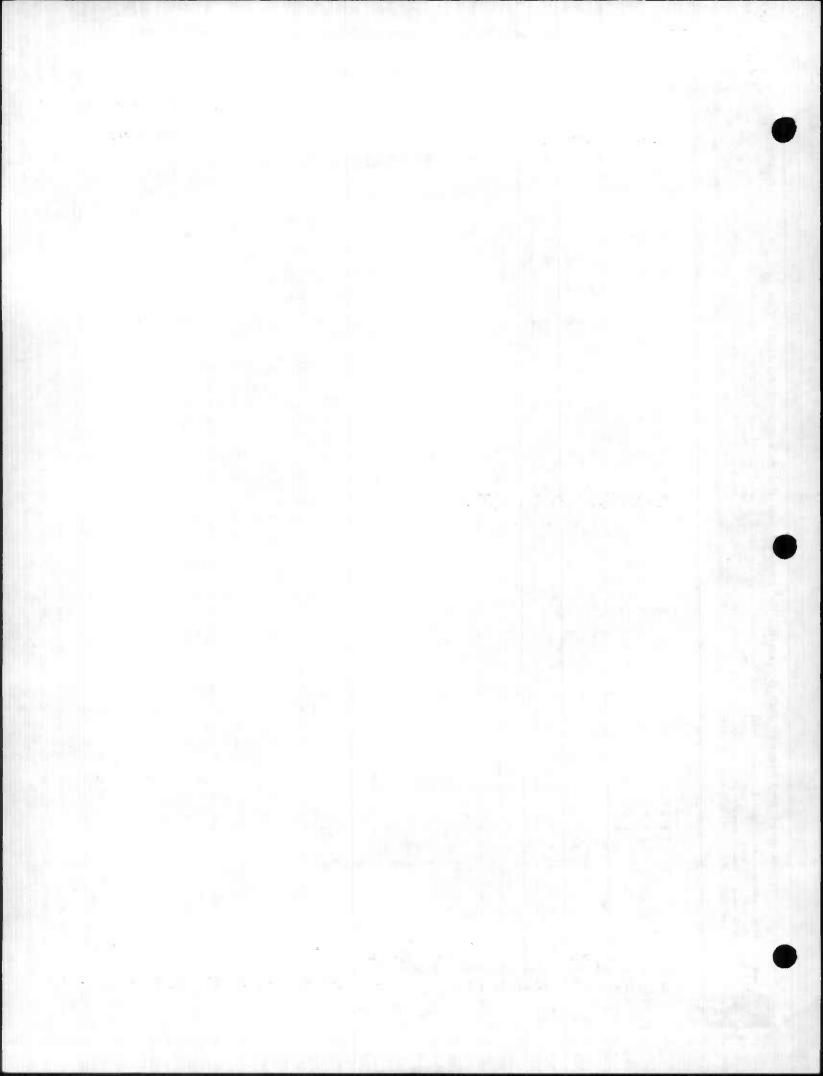
DHMH 16 Rev 6/95



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RAN	MS: #23 PART I, 27, 28A	State of Mary					4	8	21836				
Physicial	Decedent's Name (First, Middla, L.				D Guill	2. Date of De		98°	3. Tima of Death 7:30P.M.				
/Medica Examine	RAN			TAN	4b. City, Town, o	r Location of Death							
Funeral Director	5. Social Security Number 6. 090-76-2566 Usual Residence of Decedent	Sex 1	yrs. lest birthday) Yrs.	If Under 1 Year Months Days			y, Year)	(, Year) Country)					
e Maryland 8a-f show	10a. Slate 10b. County MD BALTI 10a. Street and Number		c. City, Town or Lo	BA	LTIMORE				10d. Inside City Limits 1 ☐ Yas ※XNo				
ter death v	10e. Street and Number 3 SUNNY MEADON 11. Marital Status 1 Never Married 3 Widowed 4 Divorced	N COURT T-2. 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		Was Dacedent of If Yas, specify Cut	Hispanic Origin? (ban, Mexicen, Pue	209 Specity Yas or No into Rican, etc.)	- 14. Raci Biac	ISRAEL 14. Race - American Indian Black, White, etc. Specify: WHITE					
21215-0020 d within 72 hours af giener than "natural", or the Medical Exam	15. Decedant's I (Specify only highest g		(Give	dent's Usuai Occu kind of work done DO NOT use ratire	during most of w	orking	16b. Kind of Bu						
E SES	12 17. Father's Name (First, Middle, Las ZVI	(1)		DRIVER WEISS		ama (First, Middle,	SEDAN S Maiden Surnam		SHEARY				
and 2 show seith and A n 27 is manner treumment.	19a. Informant's Name/Relationship SIMA LOTAN (W.	[FE)	92	24 EAST 2		Rural Route Number	N, NY	11210					
altimore, mit. Pages 1 ar partiment of Hea portant: If Nem ? y Injury or othe	20e. Method of Disposition **Disposition 1 Cremation 3 Cremation 3 Cremation 5 Cher (Special Content of the Content o	Removal from State		psition (Neme of metory or other plants) CEMETER		7/16/98	PINELAN						
Ball permit Depar Impor	21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or conshock, or heart failure. List only	22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, Interval Between Onset and Daath											
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a	DRUG INTOX					1	Criser and Dadin				
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying												
2 22 3	thal initiated events	CDua	Dua to (or as a consequence of):					1					
P.O. Bo that the death ed by the atter deteched for u	Part II. Other significant conditions	contributing to death but no	ol resulting in the u	inderlying ceuse g	iven in Part I.		tobacco usa co Yss 2/X(No		to the cause of death				
v 2 58	á a					24a. Wes	an autopsy ormed?	C	Vere autopsy findings vallable prior to emplation of causa death?				
= = aa (25. Was case referred to medical examinar?				26 Piaca of D	1 Death (Check only			ØYes 2□ No				
T 4 40	1 Yes 2 No	Hospitai: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie	nt 3LI DOA	ther: 4 Nursing	Home 5XX Resi			(ty)				
DIVISION OF aller death, safer death. I Director: After this of in by the funeral of	27. Mannar of Death 1 Natural 2 Accident investigati 3 XSulcida 6 Could not determine	be one Disco of Injury	At home, farm, sli pecify)	18 M 10	Yas 2 No	28f. Location (City or To	Street and Numb wn, Stete) 3 S		S ral Routa Number, MEADOW COURT				
he Hoapl n 24 hou he Funer pletely (III	29a. Certifier (Check only one) 29a. Certifying P 2X Medical Exa	rhysician: To the best of mainer: On the besis of exa and manner stated.	y knowledge, deet minetion end/or in			ce, and due to the	ceuse(s) and me						
To t To t com	29b. Signature and title of certifier	A Vla	role,		.M.E.		JULY 1.4						
5	30. Name and address of person who	completed ceuse of death Radentz			n Street	, Baltimo	ore, Mar	ylan	d 21201				
State Registra	31. Date filed (Month, Dey, Year)	32. Registrar's	Signature Davidoon-R	ndsee.									

DHMH 16 Rsv 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				State of	Marylar				lealth a Death	and M	lental Hyg	iene 9 8	2	1837
	Discortin		1. Decedent's Name (First, Middia, Las	t)							2. Date of Dea	th	Veer	3. Time of Death
	Physici /Medi								Monih July					1:00 AM
	Examir		4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death								of Death	1 5-11		
			3 Blinker Cour				16.1.	1.14			County		imore	
	Funeral Director		379-30-3072	9X 7. □M 2√2 F	Aga (In yrs.	(ast birthday) Yrs.	If Under Months		If Undar: Hours	Min.	8. Daie of Birth (Month, Day May 10	Year) 1927	9. Birthi Cour Man	olaca (Stata or Foraign ntry) yland
	E 8 m		Uaual Residence of Decedeni 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	10d. Insida City Limits
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	with the Maryian a or 28a-f show be notified at	rec	10e. Streei and Number	·	1		10f. Zip	Code			1	0g. Citizen of \	Vhat Cour	ntry?
	after death with the Maryla or items 23a or 28a-f show uniner must be notified at	ai D	3 Blinker Court				21	220				U.S.A.		
	death oms 23 or must	Funeral Director	11. Maritai Siatus	12. Waa Deced Armed Force	eni Ever in U	,S. 13.	Was Deced	dent of H	lispanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)			can Indian,
020		by	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 Yes 2 If Yes, Give Yaar or Date	□ No		1 ☐ Yes		Specify:	, ruello	rican, etc.)	Specify	k, Whita, Wh	ite
2-0	"natural", edical Exp	Completed	15. Decedent's Ed (Specify only highast grad	ucation		18a. Deced	dent's Usua	ai Occup	ation	of work	ha.	16b. Kind of B	siness/in	dustry
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2		ပိ	12	0		HO	omemal	ker						
Maryland 21215-0020	2 should be filed and Mental Hyg a marked other surradic event, I	To Be	17. Faihars Nama (First, Middla, Last) Harry Petenbri	nk			·-				ne Marga			Ls
	日本教育		19a. informant's Name/Reiatlonship (7 John Leroy Lync)								ore, Mar			Code)
Baltimore,	Page ment o ant: # ury or		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Specify)	ate	Placa of Dispo cematary, cran			ce)		Data	20c. Location -	City or To	own, Stata
Balt			21. Signature of Fundad Service Licenses Wade, Director State Anatomy Board, 655 W. Baltimore, Baltimore, Maryland 21201								more	Street		
W.			23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or a shock, or heart failure. List only one cause on aach line.									est,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	DIABETES MELLITUS								18 YE ARS		
	sate be executed hysician and the bunal-transit	iner		h	Due to (d	or es a conaeq	juence of):						1	
,00		I Examiner	Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury		Due to (or as a consequence of):									
c 68760,	certificate b nding physic use as the b	Medical	that initiated events resulting in death) Last	Due to (or as a consequance of):										
Вох	eath certific attending p	Physician/Me	U.											
	0 0 0	/sic	Part ii. Other eignificant conditione co	ntributing io deal	h but not res	uiting in the u	nderlying c	ausa giv	ren in Part i.		23b. Did to	obacco use co	ntribute t	o the cause of death
<u> </u>	requires that the de een signed by the hould be detached	by Phy	HYPERTENSIO	N, DIA	BETIC	RETI	NOPA	THY			1 🗆 Y	2 PNo	3 ☐ Pro	bably 4 Unknow
Records,	2 S C 2 S C	Completed									24a. Waa a perfor		av	ere autopsy findings vailable prior to empleiion of cause death?
	0 - 0	E O									1 🗆 Y	es 210 No	10	☐ Yea 2☐ No
Viita	ysician: The s certificate director, pag	Be (25. Wes case referred to medical examiner?						28. Piace	of Death	(Check only or	na)		
0	5 00	2	1 ☐ Yes 2 No	Hospitel: 1 I inc		ER/Outpatlen			4 LI NU		me 57 Reside			(y)
	or Attending after death. Director: After I in by the fune		27. Manner of Death 1 Natural 2 Accident 5 Pending investigation	28a. Date of (Month,	28a. Date of injury (Month, Day Year) 28b. Time of injury Work? 1 Yes 2 No					28d. Describe how injury occurred				
Division		Certification:	3 Suicida 6 Could noi be determined 28a. Place of injury - At home, farm, sireel, factory, office City or Town, Suicida 4 Homicide 4 Homicide 5 Section (Specify) 28b. Location (Street City or Town, Street City or Town,								er or Rur	al Route Number,		
	To the Hospital within 24 hours To the Funeral completely filled	edicai	29a. Certifier (Check only one) 2 Medical Example 2	rsician: To the be iner: On the basi and manne	s of axamina	wledge, death tion and/or Inv	occurred a	at the tir , in my o	ne, date and pinlon, daat	d placa, a	and due to the c ed at the ilma, d	ause(s) and me aia and piace,	enner as s and dua t	stated. o tha cause(s)
	within 2 To the comple	M	29b. Signatura and title of certifiar	10			290	. Licens	e number		2	9d. Data signe	d (Month,	Day, Year)
	->-0		•	*Or	D.			H35!	593			JULY	10,	1998
			30. Neme and address of person who's											
	Sta Registr	- 1	31. Date filed (Month, Day, Yad)		istrar's Signa		/E.,	BA]	LTIMO	RE,	MD. 2	1221		

DHMH 16 Rev 6/95

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NATHAN LIPSKY

State of Maryland / Department of Health and Mental Hygiene Q

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ASP TTEMS: #23 PART I, 27, 28A-F PER MEO G761 7-22-98 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth **Physician** LIPSKY NATHAN **JOSHUA** 1998 5:00 A JULY 13 · /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3700 LABYRINTH RD. BALTIMORE N/A | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth (Month, Day Year) | Min. | MARCH 11,1977 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Yrs. 215-90-4303 MD 21 Director Usual Residence of Dacadeni the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limita ir than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2□No Director BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21215 3700 LABYRINTH ROAD U.S.A. deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ★ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Biack, Whita, etc. 2 should be filed within 72 hours effer on and Mentel Hygiene.
Is marked other than "naturel", or there XNever Married 2 Married Maryland 21215-0020 1 Yes XXNo Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedant's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 STUDENT EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Be LIPSKY ESTHER STNREICH LARRY OL 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 permit. Peges 1 and 2 Department of Health e Important: If item 27 is any injury or other tret ans. 3700 LABYRINTH ROAD BALTIMORE, MD 21215 LARRY LIPSKY (FATHER) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) AGUDATH ISRAEL OF BALTO. 7/13/98 ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 ew1 at his that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in daath) HANGING Examiner Dua to (or as a consequance of): Examin Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaasa or injury that initiated avants resulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 2 signed by 1 Yes 2 No 3 Probably 4 Unknown Records. þ 9 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy Completed Deen **5 90 9**0 100 conficate 1 Yes 2 No 1 ∏ Yea 2 ∏ No Division of Vital 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5X Residence 8 Other (Specify) To 1 X Yes 2 □ No Pile funeral FOUND 7-13-98 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? Affor 1 Natural 5 Pending 4:55 1 Yes 2 No SUBJECT FOUND HANGING Investigation 2 Accident or Atland after death Director: 6 🕻 Could not be determined 28a. Placa of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide RESIDENCE 3700 LABYRINTH ROAD BALT.MD. Hospital 24 hours a Funeral 1 Certifying Phyaician: To the best of my knowledga, death occurred at tha tima, data and placa, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and due to the cause(s) 29a. Cartifiar Medical 18 (Check only one) To the F and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifie O.C.M.E JULY 13, 1998 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYDRUM KOREU 111 Penn Street, Baltimore, Maryland 21201 32 Pagista Saignan - Nanti all State Registrar

MUNITION ST.

FREE OF CLEANING DAY ON CONTRACTOR

THE RESIDENCE OF THE PROPERTY OF THE PERSON OF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Deta of Death **Physician** Month. MARY MACKALL AM ELLEN /Medical 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner selfmore Jakyland (renera 5. Social Security Number If Undar 1 Year If Undar 24 Hrs. Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** 1□M 20 F 217-32-1860 Yrs. AUG 15, 1925 Director VIRGINIA Usual Rasidence of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Completed by Funeral Director MARYLAND 10e. Street and Number 10g. Citizan of What Country? 1678 COURT MOUNTMOR USA. 12. Wes Dacedant Evar In U,S. Armed Forces? 1 Yas 2 No If Yas, Give Yaar or Datas: 13. Wes Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify: BLACK Specify: 3 Widowed 4 □ Divorcad 15. Decedant's Education (Specify only highast grade complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondery (0-12) Collaga (1-4or 5+) 8 ++ GRADE SHUCKER YSTER HOUSE 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Coda) 127 WARWICKS HIRE LANE D GLEN BURNIE, HD. 21061 a of Disposition (Nema of Data 200. Location - City or Town, State ERNESTINE MACKALL (DAUGHTER) 20b. Placa of Disposition (Nema of cametary, cramatory or other place) 20a. Mathod of Disposition 1 Burlal 2 Crametion 3 Ramoval from Stete CEMETERY 7-17-98 LANSDOWNE, MARYLAND 4 Donation 5 Othar (Spacify) MT, ZION 21. Signific of Funeral Sarvice Licensee 22. Nome and Address of Facily JOSEPH H. BROWN JR. FUNERAL HOME, P. A. 23a. Part1. Enter tha disaasa, or complications that caused tha death. Do not antar the mode of dylng, such as cardiac or respiratory shock, or heer failure. List only one cause on each lina. BALTIHORE, ND. 21217 Approximate Interval Between Onset end Death Immediata Causa (Finel disease or condition resulting in death) Examiner Sequantially list conditions, if any, laading to Immadiate causa. Entar Undarlying Causa (Disaasa or Injury thet Initiated events rasulting In deeth) Lest Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wara autopsy findings evailable prior to Completed 24a. Wes en eutopsy performed? complation of causa of deeth? 1 ☐ Yas 2 1 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminer? Be 26. Placa of Daath (Check only ona) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yes 21 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending

P.O. Box 68760. physician The law requires that the death certificate be the ate has been signed by the atte page 2 should be detached for Division of Vital Records.

r 28a-f show a notified at

must be n

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traumatic event, the Medical Examiner

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

Baltimore,

nt of Health a

Department of Important: If any Injury or b

Physician /Medical

Examiner

Hygiene.

funeral director, Medical Certification: To

certificate or Attending Physician: this After death. 24 hours after deatlerers Hospital

within 2 To the 0 State

the th

(Check only one) 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and Ma Certific

invastigation

6 Could not be determined

2 Accident

3 Suicida

29a. Cartifiar

4 D Homicide

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

1 TYas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Phyalcian: To the best of my knowledge, death occurred at tha tima, data and placa, and due to the cause(s) and menner as steted.

29c. Licansa number

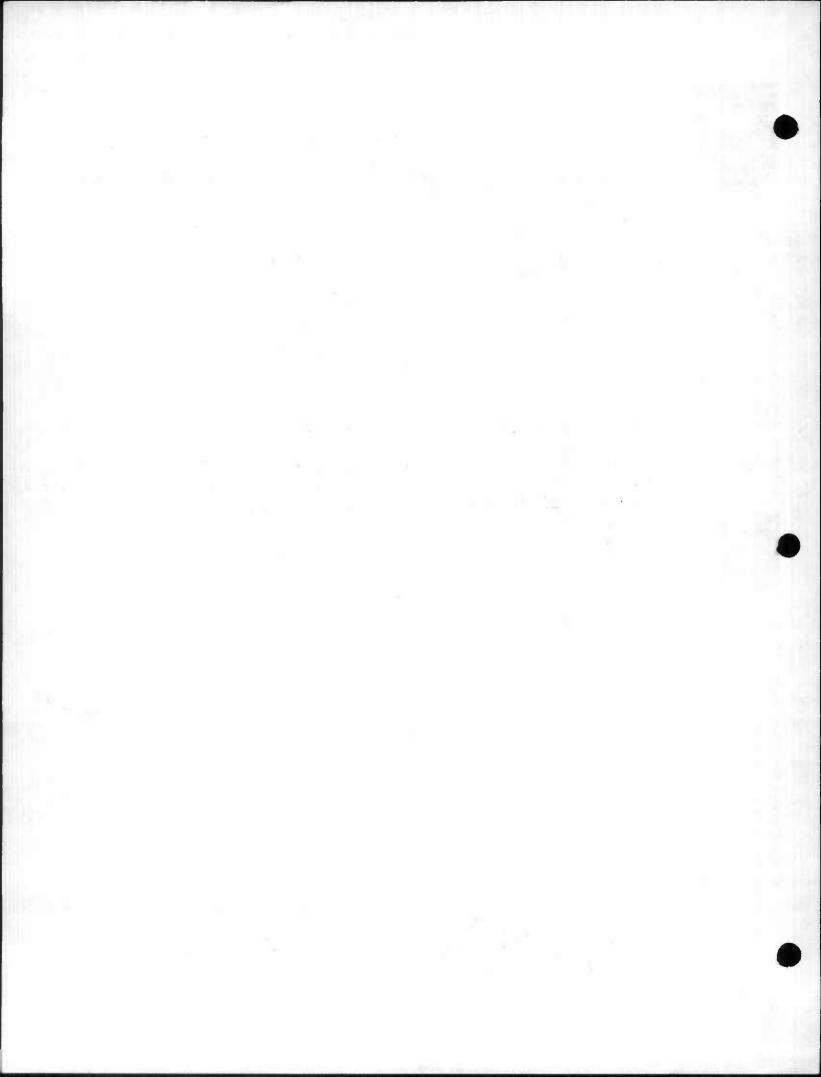
yland General

29d. Data signed (Month, Day, Year)

30, Nama and address of person who complated cause of death (item 23a) (Type, Print) m.1) Chuarts

31. Data filed (Month, Day, Yaar) 32. Ragistrar Signature JUL 161998

Registrar



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State of Maryland / Department of Health and Mental Hygiene

			Certificate	or Death	Re	g. No.				
	Physician /Medical	Decedent's Name (First, Middle, Last) GLORIA B		2. Dete of Deeth Month JULY 12	Year 1 am					
	Examiner	4a Facility Name (If not institution, give street and number) 4100 N. CHARLES ST, APT. 1	Ac. County of Death RE N/A							
_	Funeral Director	THE STREET	e (In yrs. last birthday) Yrs. If Under 1 Months	Year If Under 24 Hrs Deys Hours Min.		Year) 1926	Birthplace (State or Foreign Country) NEW YORK			
5-0020 72 hours after death with the Maryland	fanyland ahow	10a. State 10b. County MARYLAND N/A	10c. City, Town or Location BAL	TIMORE			10d. Inside City Limits 1 Yes 2 □ No			
	r 28s-	10e. Street and Number	10f. Zip (Code	10	g. Citizen of Wi	hat Country?			
	23a o	4100 N. CHARLES ST., APT.		21218		USA				
	n 72 hours after death with the Manylan "natural", or items 23s or 28s-1 show edital Examiner must be notified at lefted by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:	Ever in U,S. 13. Was Decede If Yes, specification 1 Yes 2	ent of Hispenic Origin? (Sty Cuban, Mexican, Puer XNo Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.			
2-0	72 hor	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual (Give kind of work	Occupation k done during most of wo e retired)	rking 1	6b. Kind of Bus	iness/Industry			
21215-0020	within and	Elementary/Secondary (0-12) College (1-4or 5	+) HOUSE			OWN	HOME			
pu	De fi	17. Father's Name (First, Middle, Last)	DICA		me (First, Middle, M	laiden Surname	ELGART			
Maryland	d 2 should be hand Mente 7 is marked traumatic er	VINCENT 19e. Intormant's Name/Relationship (Type, Print)	PICA	(Street and Number or R	LYN ural Route Number,	City or Town, S				
	od 2 silth ar trau	MR. BERNARD MAIZEL (HUSBAN		CHARLES ST,						
Baltimore,	t of # b	20a. Method of Disposition 1 □ Burial 2 ⊠Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Nam cemetery, crematory or off HILLTC	e of her place) OP SERVICE C	- 4-	- 1	City or Town, State COWSON, MD			
Balt	permit. Pa Department Important: any injury pncs.	21. Signature of Funeral Service License	SC	Address of Facility OL LEVINSON REISTERSTOWN	& BROS.,	INC.	. MD 21208			
		23a. Part 1. Enter the disease, or comblications that caused shock, or heart failure. List only one cause on each lir	the death. Do not enter the mode	of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death			
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	tastorlie &	Briggt C	ancor		5yrs			
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,	scuted and transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): C. Due to (or as a consequence of):								
68260,	SAL	Cause (Disease or injury that initiated events Due to (or as a consequenca of):								
9 xo	nding buse	d								
\mathbf{m}	C -	Part it. Other significant conditions contributing to death b	ut not resulting in the underlying ca	use given in Part I.	23b. Did tot	pacco usa con	tribute to the cause of death?			
s, P.O.	d by detace		1 □ Ye	s 2X No	3 Probably 4 Unknown					
Vital Records,	2 2 2				24a. Was an perform		24b. Were autopsy findings available prior to completion of cause of death?			
a B	ystcien: The law s certificate has director, page 2 Co Be Comp				1 □ Ye	s 2No	1 ☐ Yes 2 No			
	Physicien: this certificant director.	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Outpatient 3 DO	Other:	Home 5 Reside	nce 6 □Othe	r (Specify)			
n of		27. Menner of Death 28a. Date of Inju	v 28b. Time of 28	Bc. Injury et Work?	28d. Describe no		1-1 //			
Division	To the Hospital or Attending Phythin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	Accident Investigation	M Mury - At home, farm, street, factory,	1 ☐ Yes 2 ☐ No	28f. Location (Str City or Town		er or Rural Route Number,			
	pital or nurs aft vraf Dir illed in	~		t the time date and place			poor se stated			
	n 24 hound no 24 hound no 24 hound no Funer pletchy fill edical	29a. Certifier (Check only one) 1// Cartifying Physician: To the best of and manner specified and manner specifie	examination and/or investigetion,							
	Vithic To th Comp	290. Signature and title of certifier	29c.	License number D3681	4	od. Date signed	(Month, Day, Year)			
	12	30. Marre and address of person who completed cause of d	eeth (Item 23h) (Type, Print)	r Da. Si	ITE SO	4 700	osan, Mo			
	State	31. Date tilled (Month, Day, Year) 32. Registra	ar's Signeture							
	Registrar	30 1000	- Jonde M.							

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene	I Hygiene 9	State of Maryland / Department of Health and Mental Hygien	e 9
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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Daeth 3. Time of Death **Physician** Month 30,1998 21:55 MISTO JUNE LORETTA /Medical 4a. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 20, 1924 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country)
 unknown **Funeral** Days Hours 1□M 205F 579-24-1639 Yrs Director Usual Residence of Decadant the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Calvert Prince Frederick 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? ò 260 Fairground Road 20678 U.S.A. **Нетя** 23a Funeral 72 hours efter death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: by 3 Widowed 4 □ Divorced Specify: White Completed traumetic event, the Medical 15. Decedent's Education (Specify only highest grede com. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry completed) Pages 1 and 2 should be filed within ond Mental Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) 8 Mary Albert unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 of Department of Health of Important: If Itam 27 Is any Injury or other trauonce. unknown unknown 20a. Method of Disposition 20b. Placa of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stele 5 NOther (Specify) in state 22 State Admin Board, 655 W. Baltimore Street ure of Ronald Service License Wade Director Dalo Baltimore, Maryland 21201 art 1. Enter the disease, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or raspiratory arrest, hock, or haart failure. List only ona cause on each line. Onsat and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting In death) Examiner Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in daeth) Lest Dua to (or as e consequenca of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical Due to (or es e consequence of): 0 Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be datech TEX Yes 2 No 3 Probably 4 ☐ Unknown þ Pelmonen Disease 24b. Were autopsy findings available prior to Be Completed 24a. Wes an eutopsy performed? peen completion of cause of death? has certificate 1 Tyes 1 ☐ Yes 2 ☐ No or Attanding Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Natural 5 Pending death. 1 Yes 2 No Director: A Investigation 2 Accidant 6 Could not be datarmined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours after To the Funeral Dir Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mennar es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) 29a. Cartifian Medical 29b. Signetur 29c. License number 29d. Date signed (Month, Day, Year) 30. Nema and address of parson who complated cause of death (nam 23a) (Typa, Print) Dr. Sheldon E. Goldberg, M.D., Prince Frederick, Maryland 32. Registrer's Signature 31. Date filed (Month, Dey, Yeer) State Julia Davidson Registrar

DHMH 16 Ray 6/95

to been recovered as \$277 d.T.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

i icase i	State of Maryland	d / Depa		Health and		_		1842	
1. Decedent's Name (First, Middle, Last))				2. Data of De			3. Time of Death	
					Month	Day	Year		
THOMAS RICHARD 4a. Facility Name (If not institution, giva				4b. City, Town, o	July or Location of Deat	13, 199 4c. County		06:30 pm	
Greater Baltimore	Medical Cente	er		Towson	1	Balt	timor	e	
5. Social Sacurity Number 6. Sax			If Undar 1 Yaa			th	9. Birthpi	laca (Stata or Foreign try)	
217-34-9146	M 2 F	Yrs.	Months Days	Hours Mi					
Usual Residance of Dacedent	6.0				10/18,	31	MARY	ZLAND	
10a. State 10b. County	10c. City	, Town or Loc	ation				10	0d. Inside City Limits	
MD BALTI	MORE	COCK	EYSVILL	Ε				1 □ Yas 2/2 No	
10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Coun	try?	
202 MELL INCOODOLIO	יון מוכדא ער אווים ווי		21	020			C 3		
302 WELLINGBOROUG	SH WAY APT。H 12. Was Decedant Evar in U,S	13 W		030 Hispanic Origin?	(Specify Yas or No		SA e - America	en Indien	
	Armed Forcas?	if lf	Yas, specify Cu	ban, Mexican, Pue	erto Rican, atc.)		ck, Whita,		
1 Never Married 2 Married	1 ☐ Yes R ☐ No If Yes, Give	1	☐ Yes 2 No	Specify:		Specify:			
3 ☐ Widowed 4 ★ Divorced	Year or Dates:						WHIT	NE.	
15. Decedant's Educ (Specify only highest grade	cation	18a. Decede	ent's Usual Occu	pation	working	16b. Kind of Bu	usiness/Ind	lustry	
Elementary/Secondary (0-12)	College (1-4or 5+)	lifa. D	O NOT usa retir	during most of w	TO KII IY				
12th GRADE	CONUNC (1:401 ST)	FTDC	T CLASS	FNC		HOSPI	ጥአ፣		
17. Fathar's Name (First, Middle, Last)		LINO	TUMOO		ame (First, Middle				
FRANK NEARY					Y CAVENA				
19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Malling	Address (Street		Rural Route Numb	er, City or Town,			
KATHLEEN M. SCHREI	BER DAUGHTER	302	WELLTING	BOROUGH 1	WAY APT			LLE, MD	
20a. Method of Disposition			ition (Name of	DOMOOGII	Date	20c Location	City or To	21030 wn, State	
1 Durial 2 □ Cremation 3 □ R	CO	matary, crem	atory or other pl	ace)	Date	200. Eooalion	City of 10	WII, State	
4 Donation 5 Dother (Specify)		ELAND	MEMORIA	, PARK	7/17/98	HILLEN	DALE	, MD	
21. Signature of Funaral Service License			Nama and Add		12/21/20		D	- 1.00	
· /		JO	HNSON F	UNERAL H	OME, P.A.				
1/2		85	21 LOCH	RAVEN B	LVD. TO	NSON _ MD	212	286	
Immediata Causa (Final disease or complicate Causa (Final disease or condition resulting in death)	Acute infar	ct of p	pons	ing, such as card	ac or respiratory a	rrest,		Approximate Interval Batween Onsat and Death	
		as a consequ	20000				1		
	Atherosclero	osis of	f Circle	of Will	lis		1	years	
Sequentially list conditions,	Due to (or	as a consequ	ience of):				i		
if any, leading to Immediate cause. Enter Underlying									
Causa (Disaase or Injury that initiated events	Due to (or	as a consequ	ence of):				+		
resulting in death) Last	, ,						į		
Part II. Other significant conditions con	tributing to death but not resul	ting in the un	derlying cause g	iven In Part I.	23b. Dtd	tobacco uss co	ntributa to	the causs of death?	
					10	Yes 2□No	3 Prob	bably 4 Unknown	
-						1.110	04h 14/-	ere sutopsy findings	
					24a. Was perfo	an autopsy ormed?	ava	allable prior to mpletion of cause death?	
					OKC1	Yes 2□No		Yes 2 No	
25. Was casa referred to medical				26 Place of D	eath (Check only		145		
axaminar?	ospital: 15 tnpatient 2 E	'D/O	2000.0	thor			Ala constitue		
	1	R/Outpatient	3 LI DOA	4 Li Nursing	Home 5 ☐ Resi			"	
27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inje	ork?	28d. Describe	how injury occur	red		
2 ☐ Accident investigation			M 1	Yes 2 □ No					
3 Sulcide 6 Could not be	28a. Place of Injury - At hor	ne, farm, stre	et, factory, office		28f. Location (Street and Numb	er or Rura	l Route Number,	
4 Homicide	building, etc. (Specify)				City or To	wn, State)			
(Check only 2 Medical Examin	iclan: To the best of my know er: On the basis of examination	ledge, death	occurred at the testigation, in my	ima, data and pla opinion, daath oc	ce, and due to the curred at the tima,	cause(s) and ma	anner as st	ated. the cause(s)	
29b. Signatura and titla of certifiar	and manner stated.		29c. Licar	sa number		29d. Data signe	d (Month, I	Day, Year)	
M	(1)								
of the U	· rearlar	un un	D30:	206		07/15/	98		
30. Name and address of person who co	V						0.6 :		
Steven H. Pearlma			N. Cha	rles St.	Towson	MD 21	204		
31. Date filed (Month, Day, Year)	32. Ragistrar's Signatu	ira .	S						
dúrī	1330) gui	in Navids	on-Randel	2					

State Registrar

815

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiere. Irrportant: If item 27 is marked other than "netural", or items 23s or 28s-f show with injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

by Physician/Medical Examiner

Medicai Certification: To Be Compieted

Baltimore, Maryland 21215-0020

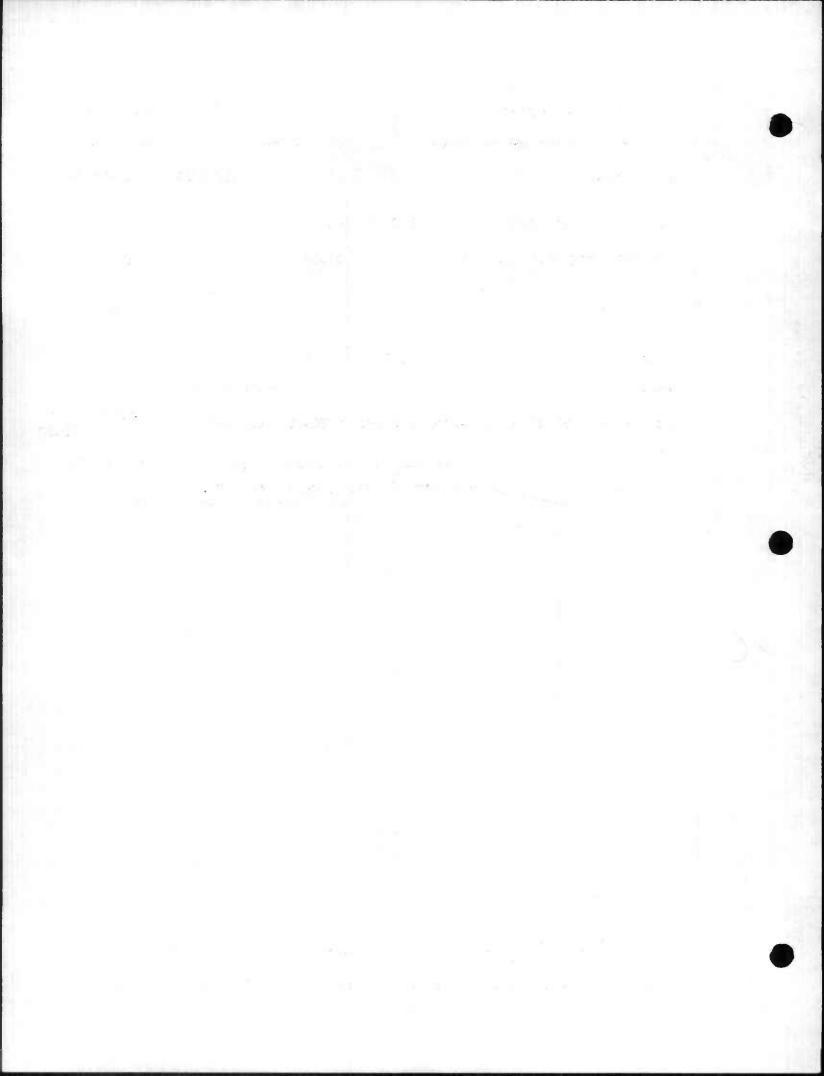
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death own within 24 hours after death.

To the Furneral Director: After this cartificate has been signed by the etterdisk completely filled in by the funeral director, page 2 should be deteched for use

Neary, Thomas

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #15 Per Anatomy Board Film G761 7-16-98RC Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Margaret G. Norfolk July 9, 1998 3:45 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pickersgill Nursing Home Towson Baltimore 8. Data of Birth (Month, Dey, Year) Oct. 24, 1908 If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days Min. Hours 1□ M 25 F 214-01-0224 89 Yrs Director Maryland Usuai Rasidance of Dacedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. inside Cltv Limits from 27 is marked other than "natural", or items 23a or 28a-f ahor other traumatic event, the Mod cal Examiner must be notified at Baltimore Maryland Towson Director 1 ☐ Yas 2 ☑ No 10e. Street and Number 10f. Zip Code 10g, Citizan of What Country? death with 615 Chestnut Avenue 21204 Funeral U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Biack, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No If Yas, Giva 1 ☐ Yas 2 ☐ No Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne eny injury or other traumatic event, the Medagones. Elementery/Secondary (0-12) Collega (1-4or 5+) Security Office Clerk 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumeme) Be Louisa Zimmerman Charles Nelson Baker 19a. informant's Name/Ralationship (Type, Print) 19b. Melling Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Carol Rigg/niece 414 Rockfleet Road, Timonium, Maryland 21093 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlai 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Paperal Service Ligenses Wade, Director ²² Name and Address of Facility Board, 655 W. Baltimore Street West o Baltimore, Maryland 21201 Rant 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** myocardial infarction Immediata Causa (Final disaasa or condition resulting In daath) /Medical minutes Examiner Dua to (or as e consequence of) Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Diseasa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Box 68760, the Dua to (or as a consequance of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Cancer BLAdder þ 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to completion of cause of death? Completed certificata has 1 ☐ Yas 2 XNo 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was casa raferred to medical axaminar? 26. Place of Death (Check only one) Hospitai: 1 inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No Certification: To this 26a. Data of injury (Month, Dey Year) To the Hospital or Attending Ph-within 24 hours after death. To the Funeral Director: After thi complately filled in by the funeral funeral 27. Mennar of Death 28c. injury et Work? 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Naturai 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homloide 15 Certifying Physician: To iha best of my knowledga, deeth occurred at the tima, dete end piece, and dua to the cause(s) and manner as steted.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and piace, and dua to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signatura and tities of conffic 29c. Licansa number 29d. Data signed (Month, Day, Year) D25205 July NO 6701 N. Charles St. Balto. md 21204 who completed cause of death (itam 23a) (Type, Print) GBMC 31. Data filed (Month, Dey, 32. Registrar's Signatura

Julia Trinda

DHMH 16 Rev 6/95

State

Registrar

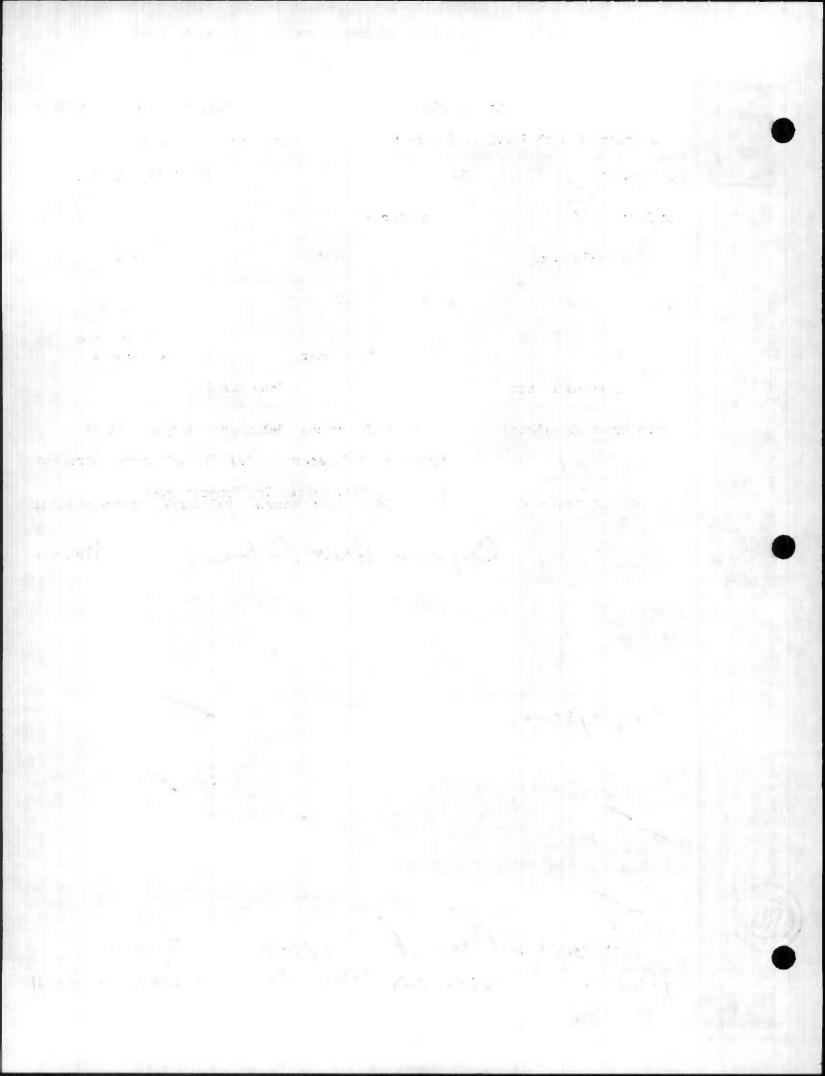
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State of Maryland / Department of Health and Mental Hygiene Q 9 2 1 8 1, 1,

			Certificate of D	Death	Re	g. No.	. 1 0 24 24
	1. Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Deeth
Physician /Madical	114	arry C Ott			July 1	15, 1998 Year	4:30 am
/Medical Examiner	4a Facility Name (If not Institution, give street an		41	. City, Town, or Loc	ation of Death	4c. County of Deat	h
	Manorcare Health Ser			Baltimo		N/A	
Funeral Director	5. Social Security Number 218-09-1738 Usual Residence of Decedent	F 80 Y	Months Days		8. Date of Birth (Month, Day, Oct 16,	Year) 9. Birt Co 1917 Ma	hplace (State or Foreign untry) ryland
yland m	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Man	Maryland N/A	Balt	imore				1XXYes 2□No
th with the Ma 23a or 28a-fe int be notified	10e. Street and Number 4669 Falls Road		10f. Zip Code 2121	1	10	Og. Citizen of Whet Co U.S.A	untry?
iore, Maryland 21215-0020 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelth and Mental Hygiena. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the West call Francher must be notified at To Be Completed by Funeral Director.		Decedent Ever in U,S. Ind Forces? If see the seed of	13. Wes Decedent of His If Yes, specify Cuber	spanic Origin? (Spen, Mexicen, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Bleck, White Specify: Whi	e, etc.
2 hours	15. Decedent's Education	168. [ecedent's Usual Occupa	tion	1	16b. Kind of Business/	
21215-0020 ed within 72 hours af ygiene. ygiene, t, the Wed call Exam Completed by F	(Specify only highest grade completed in the complete in the c	ted) (ge (1-4or 5+)	Give kind of work done du ife. DO NOT use retired)	uring most of workir	ng	Self-Emp	loyed
d 2121 filed within Hygiena. ither than "	Unk	90 (1 10.01)	Carpent	er		Construc	
bo file be file doth doth				18. Mother's Name	(First, Middle, M	faiden Sumame)	
laryland 212 2 should be filed with s marked other than summatic event, the	Charles F. Ott			Rose	Emrein		
Maryland d 2 should be file h end Mental Hy T Is merked oth traumatic event	19a. Intormant's Name/Relationship (Type, Print	196. (Mailing Address (Street a	nd Number or Rure	Route Number,	City or Town, State, 2	Zip Code)
1 and 1 and 27 Health	Mary Brown (Daughter) 38	14 Elm Aven: Disposition (Name of crematory or other place	ue, Balti	more, M	aryland_21	211
Baltimore, semit. Pages 1 at Department of Hee moortant: if Item; iny Injury or other ance.	20a. Method of Disposition 1 Buriel 2 XCremetion 3 Removal	TOTT State					
F S S E S	4 Donation 5 Other (Specify)	Green	Mount Ceme		/16/98	Baltimore,	Maryland
Baltimore, Ma permit. Pages 1 and 2 to Department of Health of Important: if item 27 is any Injury or other trail	21. Signeture of Funeral Service Licensee	leit Da	A. Alan Se 3818 Rolan		Funeral	Home Mary	land 21211
Physician /Medical Examiner	23e. Part I. Enter the dilease, or complications I shock, or heart teilure. List only one cause Immediate Cause (Final disease or condition resulting in deeth)	^'	e Hear			est,	Approximate Interval Between Onset and Death
BOX 58/50, death certificate be executed e ettending physician and id for use as the burial-transit itclan/Medical Examiner	Cause (Disease or injury that Initiated events resulting In death) Last	Due to (or as a co	insequence ot):				
Beth cer ettendir for use							
P.O. hat the delache detache	Pert II. Other elgniftcant conditions contributing Employ Serve	to death but not resulting in	the underlying cause give	on in Part I.			robably 4 Unknow
The law requires the law requires the law requires the law page 2 should be defended by					24a. Wes er perform	ned?	Were eutopsy findings available prior to completion of cause of deeth?
The law ata has page 2					1□ Ye	s 2 1No	1 ☐ Yes 2 ☐ No
Ystolen: The Lystolen: The Logical page director, page	25. Wes case reterred to medical			26. Place of Death	(Check only on	e)	
OT VITA Physician: this certific ral director,	examiner? 1 Yes 22 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA Othe	er: Mursing Hor	ne 5 Reside	ence 6 Other (Spe	cify)
nding Physian Tri Atter this e funeral di		Date of Injury 28b. Ti Month, Day Year) Inj	ury Work	at :? ?? /es 2 \(\text{No} \)	28d. Describe ho	ow injury occurred	
DIVISION OF Attanding P is after death. It Director: Attant attant ind in by the funers Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, tarrouilding, etc. (Specify)	n, street, factory, office		28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
Political Political	29a. Certifier Certifying Physician: T (Check only one) 2 Madical Examiner: On t	o the best of my knowledge, the basis of examination and manner stated.	death occurred at the tim for investigation, in my op	e, date and place, a Inion, death occurre	and due to the ca	ause(s) and manner a ate and placa, and du	s atated. e to the cause(s)
	29b. Signalure and fittle of cartifier Vittlend d	1 com	29c. License	23076		9d. Date signed (Monitor) 7 - 1.5 - 50	
V	30. Name) and eddress of person who completed	cause of death (Item 23a) (T	1	5 FALLS	RD	BAUTE	1 2 12 IJ
State	31. Dete tiled (Month, Dey, Year)	32. Registrar's Signature	00				

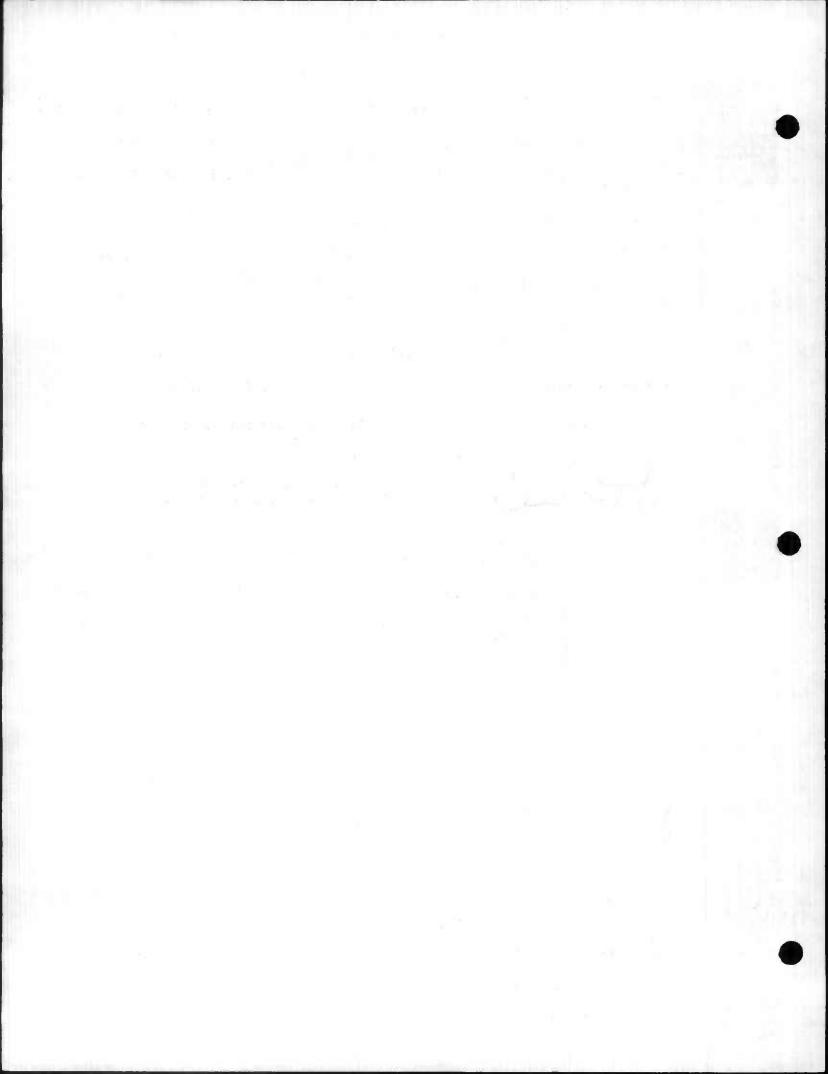
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		State of Marylan		nt of Health and te of Death		giene Reg. No. 98	2181.5
Physician	1. Decedent's Name (First, Middle, Last)		HARA		2. Date of Dea		3. Time of Dec
/Medical Examiner Funeral Director	4a. Facility Name (If not institution, gives 100 + 4	street and number) ANDE 7. Age (In yrs. I	Hospita	4b. City, Town, Glew ler 1 Yeer if Under 24	or Location of Death BURUIN Hrs. 8. Date of Birth (Month, De. May 6,	e / h y, Year)	
show	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Li
28a-f	Maryland Anne Anne Anne Anne Anne Anne Anne An	cundel	Glen B	urnie Zip Code		10g. Citizen of Wi	1 ☐ Yes 2 5
0 M	414 Brooks Court			21060		United	
or tems	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Yeer or Detes: KOREA		edent of Hispenic Origin's pecify Cuben, Mexican, Po	(Specify Yes or No- uerto Rican, etc.)	14. Rece Black Specify:	- American Indian, , White, etc. White
natur	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cetion e completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of the life. DO NOT Shuttle	vork done during most of use retired)	working	16b. Kind of Bus	Iness/Industry
eve do	17. Father's Neme (First, Middle, Last) Charles J. O'Hara	ì	Shaccie	18. Mother's	Name (First, Middle,)
fitam 27 x other tr	19a. Informant's Name/Relationship (Ty) Sherry O Hara / № 20a. Method of Disposition 1 □ ¶uriel 2 ☒ Cremation 3 □ R	7ife 20b. P	414 Broo	ks Court Gle lame of rother place)July	en Burnie.	MD 2106	
Important: Important: any injury o	4 Donation 5 Other (Specify) 21. Signature of Funeral Gervice Lipense	Met		ory 199 end Address of Facility ey-Ruddick I rain Hwy. S.	Funeral Ho		
el-fransk ledical aminer Examiner	23a. Pert1. Enter the disease, or complishook, or heart failure. List only on Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury	Acute Due to (or		dial Fi			Approximate Interval Between Onset and Deat MINUTE YEA
gned by the attending physicial be detached for use as the bur by Physician/Medical	Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other aignificant conditions con		as a consequence of	,			tribute to the cause of de
page 2 should be Completed by						an autopsy med?	24b. Were autopsy findir aveilable prior to completion of cause of death?
					101	res 2 0 No	1 ☐ Yes 2 ☐ No
I director	25. Was case referred to medical examiner? 1 ☑ Yes 2 □ No	ospital: 1 ☐ Inpatient 2 🐼	ER/Outpatient 3 1	Othor	Death (Check only only only only only only only only		(Capaih)
	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	1	28b. Time of Injury	28c. Injury at Work?		now Injury occurre	
rai Director: After I	3 Sulcide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factor)	ory, office	28f. Location (S City or Tox	Street end Numbe vn, State)	r or Rural Route Number,
ma Funda pretoly ii Aedical	(Check only one) 2 Medical Examin	ician: To the best of my knowner: On the basis of examinational and manner stated.	ion and/or Investigation	on, In my opinion, death o	occurred at the time,	date and place, ar	nd due to the cause(s)
0.8	29b. Signature and title of certifier	Jomo	puty 2	9c. License number $D = 060$			(Month, Dey, Year)
	30. Name and address of person who	nonted cause of death (Item	23a) (Type, Print)	695 A	meric A	Ct.	21035
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture				

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Month **Physician** Ellen Talbert Oursler July 10, 1998 8:25 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 13, 1917 6. Sax Birthplace (State or Foreign Country) **Funeral** Days Hours 578-05-8143 1 □ M 25 F Months 80 Nov. Director Maryland **Usual Residence of Decedent** the Maryland 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Montgomery Silver Spring 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3512 Fiske Terrace 20906 U.S.A. death Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Maritat Status Bleck, White, etc. filled within 72 hours after Hyglens. ther than "natural", or its 1 Never Married 2 Merried 1 Yes 2 No
If Yes, Give
Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: 2 White 3 ☑ Widowed 4 ☐ Divorced netural Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mentel Hyglen Important: if Item 27 le marked other the eny injury or other traumatic event, the DBDS. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) 8 Dallas Talbert Anna Marie Talbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Oursler, Sr./son 2133 Countryside Drive, Silver Spring, Maryland 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20s. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Nema end Address of Facility
State Anatomy Board 655 W. Baltimore Street Wade Director Ronald S Baltimore, Maryland 21201 Enter the disease, or complications that caused the death. Approximate Interval Between Onset and Death Do not enter the moda of dying, such as cerdiec or respiretory arrest, **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physician and the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The lew requires that the death certificate be executed Due to (or es e consequence of): Box 68760. edical that initiated events resulting in death) Last Dua to (or es e consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. been signed by the should be detach 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? pege 2 s 1 Yes 2 No 1 Yes 2 No certificate Division of Vital director. 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 0 1□ Yes 21 No 1) Synpatient 2 ER/Outpatient 3□ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and #19 of certifier 29c. License number 29d. Dete signed (Month, Day, Year) lause of death (Item 23a) (Type, Print) Prair 32. Registrar's Signe State

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Registrar

whia David

March March & Comment

800

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

hysiciar	n	1. Decedent's Name (First, Middle, Last)	, ,		tificate of		2. Date of De Month	Reg. No.	Year 3. Time of Death
Medica xamine		4a. Facility Neme (If not institution, give street and numb	erla er)	nda		4b. City, Town, or Lo	ocation of Deet	h 4c. County	
neral ector		5. Social Security Number 7. M 2 F Usual Residence of Decedent	Age (In yrs.	lest birthdey) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De		Birthplace (State or Foreig Country) Maryland
notified at		10a. State 10b. County Maryland Baltimore		y, Town or Loc					10d. Inside City Limite
nottre	Jecre	10e. Street and Number	Dal	timore	10f. Zip Code			10g. Citizen of	1 ☐ Yes 2 ☒ No
unit be	2	4514 Raspe Avenue			21206			U.S.A	
deal Examiner must be notified	2	11. Maritel Stetua 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? ⊒kNo		/as Decedent of I Yes, specify Cub	lispanic Origin? (Speen, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ce - American Indien, ck, White, efc. y: White
Completed	ombiered	15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-44)	or 5+)		ent's Usual Occup ind of work done O NOT use retire 1 Clerk	pation during most of works d)	ing		usiness/industry
Be C	0	17. Father's Name (First, Middle, Last) William Frederick Ober	lander	r		18. Mother's Name		, Ma <i>lden Sum</i> er	ne)
any Injury or other traumatic event, once. To Be C	2	19a. Informant's Name/Relationship (Type, Print) Janet Gosnell/sister		19b. Mailing	Address (Street Raspe Av	end Number or Run venue, Bal	al Route Numb	er, City or Town	, Stete, Zlp Code)
ury or ours		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from Sta 4 ᡚ Donation 5 □ Other (Specify)	0	lece of Dispos emetery, creme	ition (Name of etory or other ple	се)	Date	20c. Location	- City or Town, State
any Inj	1	21. Signeture of Funeral Service Licensee. Wade,	Direc			Soffy Board Maryland		V. Balti	imore Street
clan lical iner		23a. Part1. Enter the disease, or complications that caus hock, or heart failure. List only one cause on each limmediate Cause (Final disease or condition resulting in death)		Rect r as a consequ	al Ad	enscare			Interval Between Onset and Deeth
Physician/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest		r as a conseque					
ed for use		dd	but not resu	ulting in the unc	dedving cause on	ren in Part I.	23b. Did	tobacco use co	ntributs to the cause of death?
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2 shou		,					24a. Was perfo	an eutopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
or, page		25. Was case referred to medical						res 2 No	1 UVES NO
direct G	1	examiner? 1 Yes 2 No Hospital: 1 Inpe	itient 2 🗆 8	ER/Outpatient	3 DOA Oth	28. Place of Death er: Wursing Hor			ner (Specify)
60 00		27. Manner of Death 1 Natural 5 Pending (Month, I	njury Dey Year)	28b. Time of Injury	28c. Injur Wor M 1	y at		now injury occur	
		4 Homiciae building,	etc. (Specify)	et, factory, office		City or Tox	vn, Stete)	per or Rural Route Number,
nplately fil		29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner	or examinati	vledge, death o ion and/or inve	stigation, in my o	pinion, death occurre	and due to the ed at the time,	cause(s) and ma date end place,	anner as atated. and due to the cause(s)
E COU		196. Signature and title of chiller Medica		endy	29c. Licens	7118 † Pd #203		29d. Date signe 7/136	d (Month, Dey, Year)
	3	0. Name and address of parson who completed cause of	death (Item	23a) (Type, Pr	rint)		2120		

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

		State of Maryland / Departme	ent of Health and Mate of Death		ene 98	218	48
		1. Decedent's Name (First, Middle, Last)		2. Date of Death			na of Death
	Physician /Medical	James William Pearce		July 8		ear	14:10
i N	Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Lo		4c. County of I		
8		SHADY GROVE ADVENTIST HOSPITA	L ROCKVII	LE	MONT	GOMERY	Z
	Funeral	Month	dar 1 Yaar If Undar 24 Hrs. ns Days Hours Min.	8. Data of Birth (Month, Dey,	Yeer) 9.	Birthpiaca (Sta Country)	ate or Foreign
τ	Director	212-05-5980 93 ^{Yrs.}		March 2	29,1905	Mary	land
pue	ž	Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location				10d. Insid	da City Limits
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the state of	rect	•	Zip Coda	10	g. Citizan of Wha	at Country?	
with	3a o	5621 Plymouth Road	21214		U	ISA	
death	r items 23s or 28s-fe sper must be newfeet Funeral Director		cedent of Hispanic Origin? (Sp pecify Cuban, Maxican, Puerto	ecity Yes or No-		American India	n,
5-0020 72 hours efter death with the Maryland	0 5	1 Never Married 2X Married 1 Yes 2XXNo	pecify Cuban, Maxican, Puerto	Hican, etc.)	Specify:	Whita, atc.	
5-002C	- E	3 Widowed 4 Divorced Yaar or Dalas:	EQ.110 Oppony.			white	9
2 2	ygiene. ner than "natur. nt, the Medical. Completed	15. Decedant's Education 16a. Decedant's U (Specify only highest grade completed) (Give kind of	sual Occupation work done during most of work Luse retired)	ino	6b. Kind of Busin		
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A D	Hygie Tr. C	12 Draftsma 17. Father's Nama (First, Middle, Last)	18. Mothar's Name			. 1 1 0 0 0	J •
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Should	mert met		ass (Street end Number or Run				
Z 2	alth a 27 la r trai	James H. Pearce Son 16513	Killdeer Dr	Rocks	,ille	MD 203	255
s is	of He Hern	20a. Mathod of Disposition 20b. Place of Disposition (f	Killdeer Dr	Data 2	Oc. Location - Cit	ty or Town, Stat	ia
altimore,		10 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify)	Memorial 7	/15/98	Elders	burg,	MD
alit.	Department Important: I any Injury o phose.	21. Signature of Funaral Sarvice Licenses 22. Nama	and Addrass of Facility				
n a	8 5 5 8	Bure 363	gee-Henss Fu	neral h	dome, P	A.	1 1
		21. Signature of Funaral Sarvice Licenses 22. Nama Bure 363 363 23. Fart 1. Enter the expense, or complications that ceused the death. Do not antar that me shock or heart in turn. List only one ceuse on each line.	noda of dylng, such as cardiac	or raspiratory arra	st,	D 212	imate Batween
Ph	ysician					Onsat	end Death
,	Medical aminer	Immediata Causa (Final disaasa or condition a. Gastro-Intestivi	a) lokedir	va		da	u <
^		resulting in death) Dua to (or as a consequence of		J			
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	been signed by the attending should be detached for use as letted by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlyin	g ceuse given in Part I.	23b. Did tot	oacco uae contri	ibuta to the ce	uee of death?
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ecords law requires	een s			24a. Was an perform		24b. Wara auto available p complation	rior to
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Of VITAL	certificate has b lirector, page 2 s	25. Was cesa referred to medical axaminer? Hospital:	26. Placa of Deat				
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- X:	rs after death. al Diractor: After t led in by the funera Certification:	4 ☐ Homlcide building, atc. (Specify)		City or Town,	State)		
alidac	houn In fille	29a. Certifiar 12 Certifying Physician: To the best of my knowladga, daath occurr.					
he Ho	within 24 hours after death. To the Funeral Diractor: After this certifice completely filled in by the funeral director, Medical Certification: To Be ((Check only one) 2 Medical Examinar: On the basis of examination and/or investigate and mannar stated.					
To	To the	29b. Signatura and titla of certifiar	29c. Licansa number		d. Data signed (ar)
		D. Hombrand	031341		July o	8,10	198
1	25	30. Name and address of person who complated ceusa of death (Item 23a) (Type, Print)	0 11 0	1	1		
- (, -	Shady Grove Adventist Hospital	Kockulle, IV	lary and	7		
	State Registrar	31. Date filed (Month, Day, Year) 32. Ragistrar Dignates 33. Ragistrar Dignates	dall	1			
	riegisti iii	JUL TO 1930					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Amend: #19b Per FH Film G761 7-16-98RC 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** EDWARD, PARKER, SR JULY 2:00 AM 15 /Medical 4a, Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ledi Balt If Under 24 Hrs. en er If Under 1 Year timore 5. Social Security Number **Funeral** Days Months Hours 219-16-1839 Usual Residence of Decedent Maryland 120 M 2□ F Director de the Maryland 10b. County 10e. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examinal must be notified at 10d. Inside City Limits Maryland 1 ¥Yes 2 No Funeral Director imore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2/20 anaga 72 hours after death 14. Raca - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☑Yes 2 ☐ No If/Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Blac Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. PO NOT (see retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) aborer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Su en (wife) 19b. Mailing Address (Street and Number or Aural Route Number, City or To 19e. Informent's Name/Relationship (Type, Print) Mrs. Bernic ParKer 20b. Placa of Disposition (Neme of cemetery, crematory or other pleca) 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State ood lawn 4 □ Donetion 5 □ Other (Specify) Funeral Service Upensee

22 Name and Address of Secility

JOSEPH L. KUSS, Funer

22.7.7.2. W. North Ave. E

27.7.7.2. W. North Ave. E

1. Second of the caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, the second of the cause on each line. 21. Signature of Funeral Service Upensee uneral 21216 Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final SEPS15 with FUNGEMIA DAY disease or condition resulting in death) Examine Due to (or es e consequence of): Physician/Medical Examiner PNUETTONIA 14 DAYS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760 Due to (or as e consequence of) USB P.O. signed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 € Unknown FISTULA with RECTAL Records. Completed by 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Was an autopsy performed? CARCINOMA RECTUM. HYPOTHYROIDISM 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 (Natural 5 Pending Investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) and menner stated. 29a. Certifier Medical To the Fune (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

23300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATEL SUDHIR, D

Liberty Medical Levez dibenty Rd.

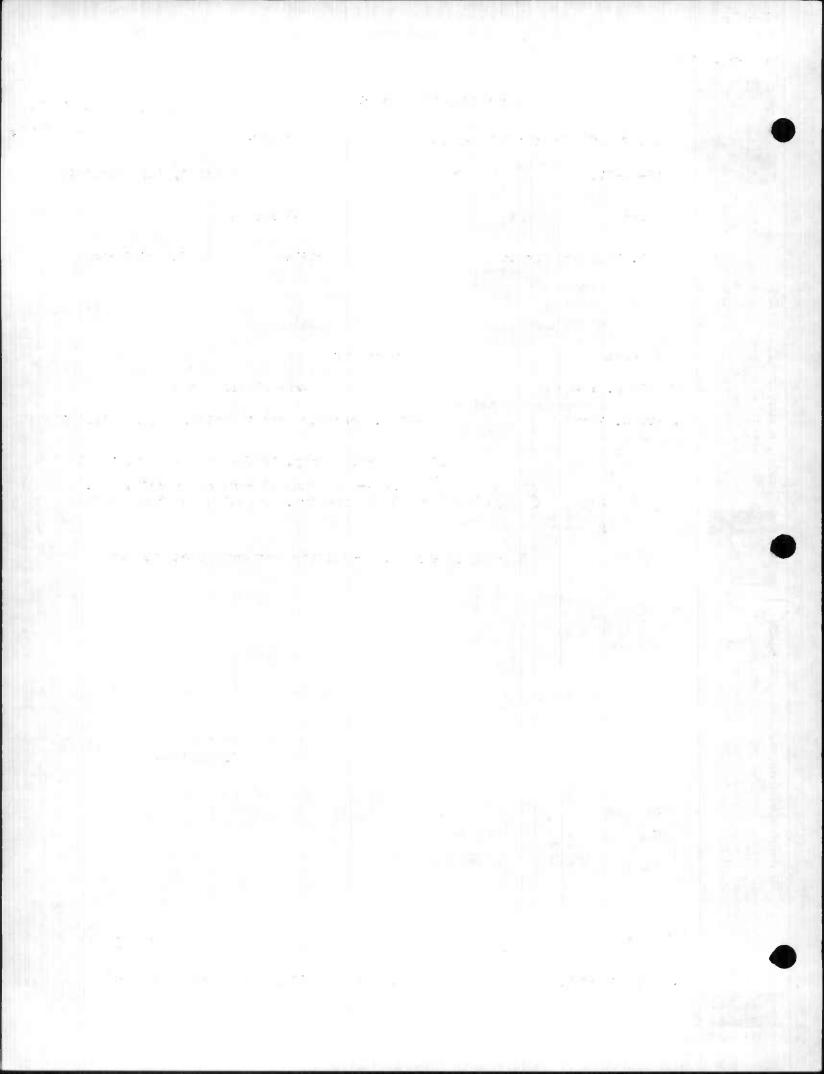
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature Julia Davidson-Randale JUL 1 6 1998



	Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
THE DIONA	State of Maryland / Department of Health and Mental Hygiene

ERINE P	LONA		Ce	rtificate	of Death		Reg. No.	5 2	850
hysician	Decedent's Name (First, Middle, Last	Katherir	e Theres	a Plon	a	2. Dete of Dea Month JULY	Day 199	Year	3. Time of Death 4:40 AM
dical niner	4a Facility Name (If not institution, giv	e street and number)			4b. City, Town, or		-		4.40 Mi
Hilliei	HOPKINS BAYVIEW	MEDICAL CEN	TER		BALTIMO	RE		I.	N/A
ral or	218-42-8730	ex	yrs. last birthdey; Yrs.	If Under 1 Months D	rear If Under 24 Hrs. ays Hours Min.	(Month, Da	y, Year) 9,1945	9. Birthplace Country) Virgi	e (State or Foreign) inia
by Funeral Director	Usuel Residence of Decedent 10a. Stete 10b. County	10	c. City, Town or Lo	ocation				10d.	Inside City Limits
Director	Maryland	N/A			Baltimo				17 Yes 2□No
al Dire	10e. Street and Number 432 N. Robinson	Street		10f. Zip Co	21224		10g. Citizen of V United		
by Funeral	11. Marital Status 1 Never Married ※外 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	In U,S. 13.	Was Deceden If Yes, specify 1 ☐ Yes 2X	t of Hispenic Origin? (S Cuban, Mexican, Puert Mo Specify:	pecify Yes or No o Rican, etc.)	14. Race Blac Specify	e - American k, White, etc.	
Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usuel Co kind of work of DO NOT use i	ione during most of wor	rking	16b. Kind of Bu	siness/Indust	try
ошо	Elementary/Secondary (0-12) 12 Years	Coilege (1-4or 5+)		memake			Own	Home	
Bec	17. Father's Name (First, Middle, Last)				18. Mother's Ner	ne (First, Middle,	Maiden Sumam	Θ)	
0	Donald E. Levesqu				Mary Th	neresa L	ang		
	19a. Informant's Name/Relationship (Type, Print) Husbar			treet and Number or Au inson Stree				1118
	Henry J. Plona 20a. Method of Disposition		0b. Place of Dispo			Date	20c. Location -	- A	
	1 Burial 20 Cremation 3 4 Donation 5 Other (Specific	Removal from Stete	cemetery, cre	matory or othe	e Corp. 7/1			, Mary	
	21. Signeture of Funeral Service Licer	See C		uda-Ru	ddress of Facility Ck Funeral				
	23a. Part1. Enter the digrasse, or com shock, or heert fathers. List only	Nications that caused the			se Ave. Du			Ac	ZZ pproximete tervel Between
edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last	bDue	to (or as a conse	quenca of):					
2	resulting in deeth) Last	d							
Physician/	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	inderlying caus	se given in Part i.	23b. Did	tobacco uss cor	ntribute to th	ne causs of death?
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Certification:	27. Menner of Deeth Language State			М	Injury at Work? 1 Yes 2 No		now Injury occur		Touto Atumbos
	4 Homicide determined	28e. Piaca of Injury - building, etc. (5		reet, factory, o	пісе	City or To	Street and Numb vn, Stete)	er or nurar n	oute ryumber,
edicai		ysician: To the best of m niner: On the basis of exa end menner stated							
×	29b. Signature and title of pertifier	11			icense number		29d. Date signe		
	1 Cenny	Chert no			O.C.M.E		JULY	15, 19	998
	30. Name end eddress of person who Dennis Chute M.D.		(Item 23a) (Type 111 Per	nn Stre	et, Baltim	ore, Mar	yland 2	1201	
State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Panda 92					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 14, 1998 **Physician PINCUS** 5:27 AM JULTUS /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE CHERRYWOOD FUTURE CARE REISTERSTOWN Birthpleca (Stata or Foreign Country) If Under 1 Year 8. Data of Birth (Month, Dey, Year) NOV . 22, 1913 5. Social Security Number Sex XXM 2□F 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 84 Yrs. MD 215-18-6489 **Director** Usual Rasidenca of Decedan the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or hems 23s or 28s-f show traumatic event, the Modical Exemptor must be notified at 1 ☐ Yes 2 No Director BALTIMORE MD BALTIMORE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21208 APT. 9 U.S.A. 2 POMONA WEST death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "naturel", or her ury or other traumatic event, the Medical Energy of the traumatic event, the Medical Energy of the contractions of the cont 1 Never Married 2 N Married Maryland 21215-0020 1 Yes ŽXNo Specify: WHITE Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highast grada completed) College (1-4or 5+) Elementery/Secondary (0-12) **PHOTOGRAPHER** GOVERNMENT 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Be SILVER MAX **PINCUS** ANNA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Reletionship (Type, Print) CELIA PINCUS (WIFE) 2 POMONA WEST APT. 9 BALTIMORE, MD 21208 altimore, 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other placa) 20c. Location - City or Town, State Date 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) permit. Page Department of important: If eny Injury or once. 7/15/98 BALTIMORE HEBREW REISTERSTOWN, MD 22. Name end Addrass of Facility 21. Signature of Fynaral Sarvice Licensi SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 w 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** month. /Medical immediate Cause (Finel disaase or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner FAILUN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): HASCUD Division of Vital Records, P.O. Box 6876 Physician/Medical Due to (or as a consequence of): 980 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 10 3 Probably 4 Unknown Julila. P 24b. Wera autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed page 2 has 2 No 1 □ Yes 2 □ No certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) Other: 4 Qursing Home 5 Residence 6 Other (Specify) 10 1 Yes No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directorn John Completely filled in D Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only one)

State Registrar

S.H. MACINON 31. Date filed (Month, Day, Year) 16 199

Modem

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of cartifier

3635 Old Coast Ad BAIN- MAY 21708 32. Registrar's Signature

helia Devida

29c. License number

004701

29d. Data signad (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

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			C	ertificate	e of i	Death			Reg. No.	1,,,	. 1006
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Physician	Eva M.	Royston						Month July	14, 199	Yeer 8	7:30 pm
/Medical	4e Facility Neme (If not institution,				4	b. City, To	wn, or Lo	cation of Death	-		
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after death v	3245 Chestnu	12. Was Decedent	Ever in IIS 1	3 Was Decen	212		igin? (Sp	ecity Yes or No	U,S	a - Amaric	can Indian.
5 5		Armed Forces?		it Yes, spec	city Cube	n, Mexicar	n, Puerto	Rican, etc.)		ck, White,	
by F	1 Never Married 27 Marrie	IT Yes, GIVE	40	1□ Yes 2	2 No	Specify:			Specif	Ameri	ican Indian
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Department important: ii any injury o once.	6 60	1-4	\cap						cal Home		
	M. Mila	n Buk	h	3818	Rol	and A	venu	e, Balt	imore,	Mary	land 21211
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath Month Reid 2:40 p.m OUI 13 98 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death OF MARIJAND MEDICINE BAIL NORE

7. Aga (In y/s. last birthday)

If Undar 1 Year If Undar 24 Hrs. 8. Da

Months Days Hours Min. (M. DEATON UNIVERSITY Birthplaca (Stata or Foraign Country)
 A 5. Social Sacurity Number 6. Sax 1 M 2□ F Yrs. 579-22-3408 Usual Rasidanca of Decedent 10a. Slata 10b. County 10c. City, Town or Location 10d. Insida City Limits Baltimore NA 12 Yas 2 No Ma 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Dak 372/ Huenul 21207 .5A 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, alc.) 11. Marital Status 14. Race - Amarican Indian, Black, Whita, alc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 Yas 2 No Black 3 Widowed 4 Divorced 15. Decedant's Education (Spacify only highast grada completed) 16a. Decedant's Usual Occupation
(Give kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Coilege (1-4or 5+) ente th grade NA 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maldan Surnama) Smith Reig saac 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) Daltimore, Md 20c. Location - City or Town, Stata Keid da 20a. Mathod of Disposition 20b. Place of Disposition (Nama of carpatary, cramatory or other place) Data 1 Burial 2 Cramation 3 Ramovai from Stata Randallstown, red 7-18-98 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licenses 0 0 23a. Part 1. Entar tha disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediata Causa (Final disaasa or condition rasulting in death) . End Stage Sequantially list conditions, if any, laading to immadiata causa. Enler Undarlying Ceusa (Disaasa or Injury that initiated avants rasulting in daalh) Last Due to (or as a consequence of) pertension Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 Yes 1 ☐ Yas 2 ☐ No 25. Was casa referred to madicat axaminar? 26. Piece of Deeth (Check only ona) Hospitai: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury at Work? 27. Mengar of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No 2 Accident invastigation 6 Couid not be datarmined 3 Suicida 28a. Placa of injury - Al home, farm, streat, factory, offica building, atc. (Spacify) 28f. Location (Straet and Number or Rural Routa Number, City or Town, Steta) 4 | Homicide

/Medical Examiner Records, P.O. Box 68760 Division of Vital

Physician

/Medical

Examiner

Directo

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Funeral

Director

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Items 23a

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Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "n any Injury or other traumate.

Physician

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Physician/Medical

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29a. Cartifiar

29b. Signature and titia of cartifiar

other traumatic event, the Medical Examiner must be notified at

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State Registrar Prehta, M.D.

29c. Licansa number D34974

Certifying Phyaician: To the best of my knowledge, deeth occurred at tha time, data end piace, and dua to tha causa(s) end menner es steted.

| Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and piace, and dua to the causa(s) and manner stated. 29d. Data signed (Month, Day, Year)

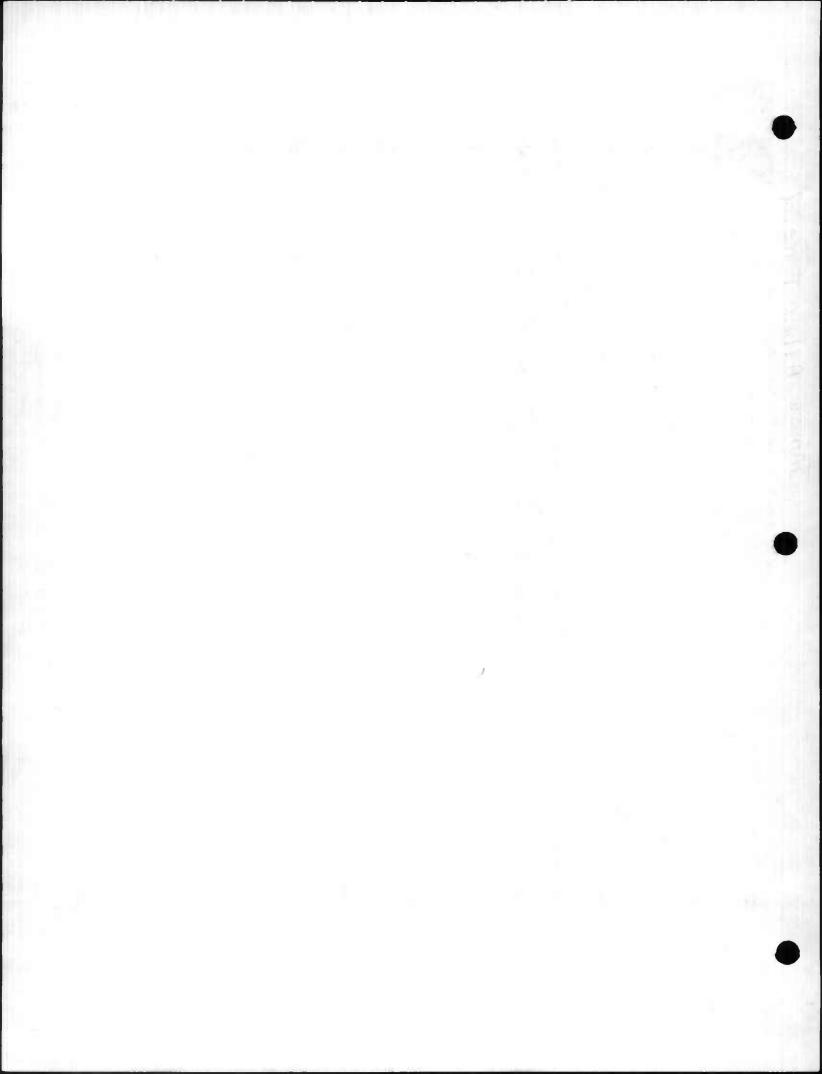
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30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

8775, Cloud leap ct, # 224, Columbia, MD 21045

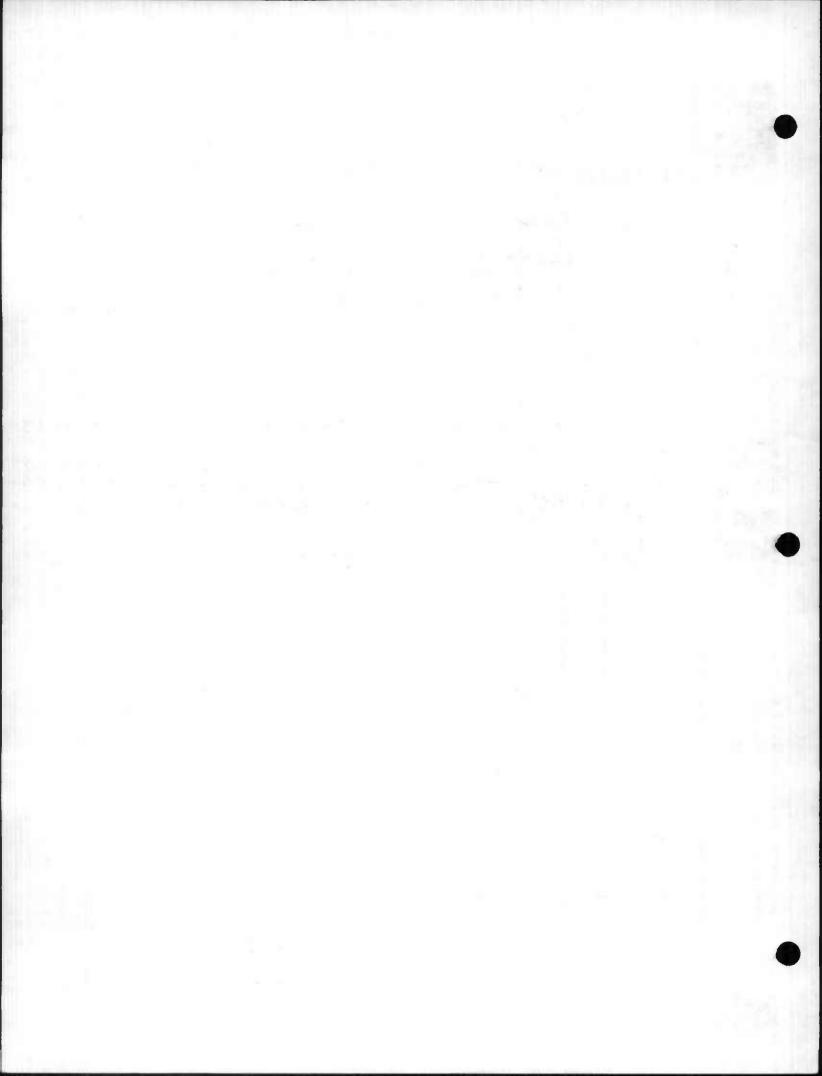
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

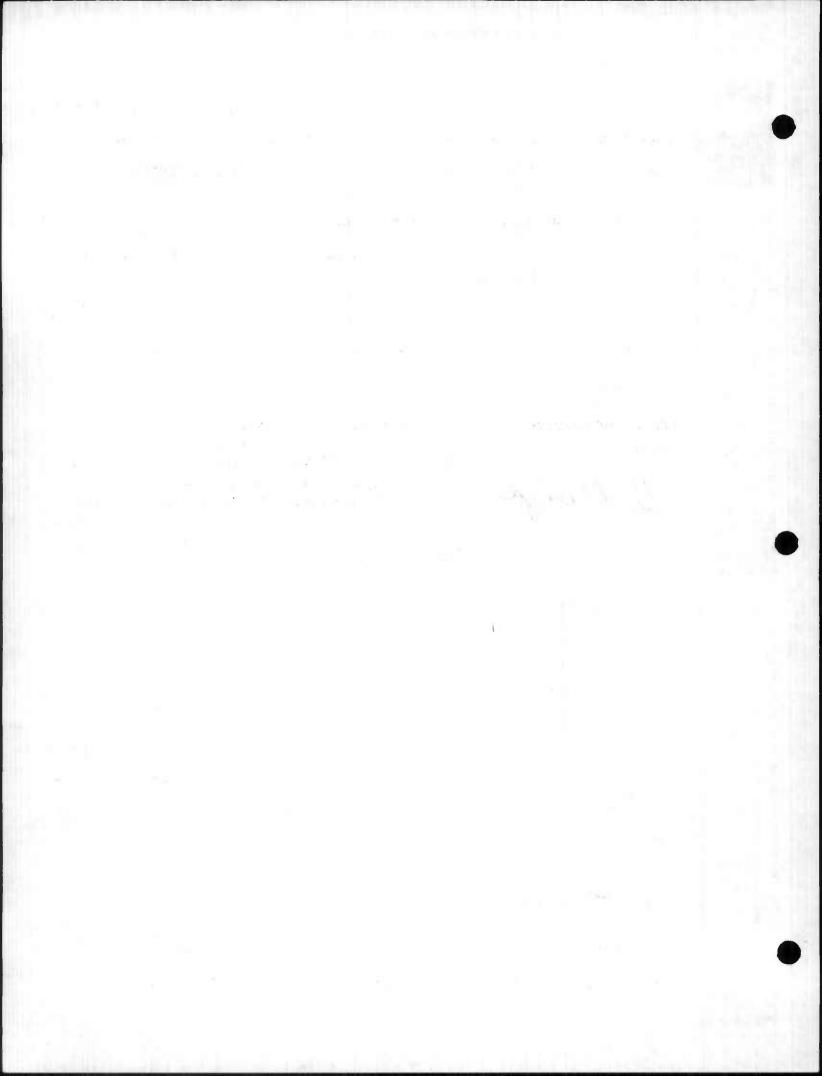
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anyland ahow		10a. State 10b. County	10c. (City, Town or Location				10d.	Inside City Limits
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<u> </u>	Ē	1 Navar Married 2 Merriad	Armed Forces? 1 X Yes 2 □ No If Yes, Give		cedent of Hispenic Origin? (pecify Cuban, Mexican, Puer	to Ricen, etc.)	Bie	ck, White, etc.	
21215-0020 d within 72 hours efter piene. r than "naturel", or tee	by	3 Widowed 4 Divorced	If Yes, Give Yaar or Dates:	WII 1□ Yes	2/0 No Specify:		Specif	BLA	CK
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Pege Pege nent int: #		1X Burlel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special	JRemovel from State (y)	APRISON	FOREST	7-20-98	Ourale	as Hil	IS MA
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Vision Attending or death. sector: After	Certification:	3 ☐ Suicide 6 ☐ Could not b	e Ope Disea of Injury At	home, farm, street, fect		28f. Location (Street end Numb	er or Rural Ro	oute Number.
Diversion of the direct	ert	4 ☐ Homicide determined	building, etc. (Spec	cify)		City or Tov	vn, Steta)		
DIVISIO To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fi	edical (29e. Certifier (Check only one) 1	systcian: To the best of my kr niner: On the basis of examin	nowledge, death occurrention end/or investigeti	ed et the time, dete end place on, in my opinion, deeth occ	e, end due to the	ceuse(s) end mo	enner es stete	d. ceuse(s)
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les 101	J .								
211		30. Name and address of person who Rm 20 6 31. Date filed (Month, Day, Year)	32. Registra 5 Sign	autau st	neet Ba	etimore	md	2/	20/



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				State o	of Marylan	nd / Dep <i>Ce</i>	artment ertificate	of F	lealth and N <i>Death</i>		iene g	3 21	855
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	Exami		4e. Facility Neme (If not institution, give Mariner Health C		,	-		4	b. City, Town, or L Laurel	ocation of Death	4c. County	of Deeth	25
	Funerai Director		5. Sociel Security Number 6. Se		7. Age (In yrs. 98	last birthday Yrs.	If Under 1 Months	Year Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, Feb. 23		O Diethologo	(Chata on Founier
yland	Now at		Usual Residence of Decedent 10e. Stete 10b. County		10c. Cit	y, Town or L	ocation					10d. lr	nside City Limits
ne Ma	and the	Director	Maryland Anne Ar	undel		Gle	n Burn					1	☐ Yes 2☐ No
with t	3a or 2		10e. Street end Number 8 4th Ave.				10f. Zip 0			10	og. Citizen of V United	Whet Country? States	5
20 s after death	Health and Mental Hygiene. Item 27 is marked other than "natural", or flems 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at	y Funerai	11. Meritel Stetus 1 Never Merried 2 Married	12. Wes Dece Armed For 1 Tes If Yes, Give	2 No	,S. 13.	Wes Decede If Yes, specif	fy Cube	Ispenic Origin? (Spen, Mexicen, Puerto	ecify Yes or No- Rican, etc.)		e - Americen tnick, White, etc.	
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Aary 2 shot	is man		19e, Informent's Neme/Reletionship (T	ype, Print)		19b. Meil	ing Address (Street	end Number or Rur	el Route Number,	City or Town,	Stete, Zip Code	9)
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Balt	Departmen important: any injury anse.		21. Signature of Funeral Service Licens	100 D		K	2. Neme end Lrkley-	Addre:	ss of Fecility Idick Fun	eral Hom			
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Po	sit	niner	_	b			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
8750, ate be execut	physician and the burial-transit	ai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	C	Due to (o	r es e conse	quence of):						
£ 0	attending phys I for use as the	VMedical	thet initiated events resulting in deeth) Lest	d	Due to (o	r es e conse	quence of):						
death cer	e atter	Physician/M	Pert II. Other significent conditions co	ntributing to de	eath but not res	ulting in the i	underlying cau	use giv	en In Pert i.	23b. Dtd tol	oscco use cor	tribute to the	cause of death?
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ecords, law requires t	6) C/	Completed b				_				24e. Wes er perform		avelieble	utopsy findings e prior to ion of ceuse ?
T a	page.	Con								1 □ Ye	s 2000	1 ☐ Yes	200
OT VITAL Physician: 7	certificate irector, pa	o Be	25. Was cese referred to medical exeminer? 1 ☐ Yes 2 ☑ Ho	Hospital:				Oth	26. Plece of Deet				
E 5	th. After this funeral di		27. Menner of Death 1 Avalurel 5 Pending 2 Accident investigation	28a. Dete		28b. Time of Injury		c. Injun Worl	4 Havursing Ho	me 5 Reside 28d. Describe ho			
2 3	gatter death. Director: Al	Certification:	3 Sulcide 6 Could not be determined	28e. Plece buildin	of Injury - At hong, etc. (Specify	ome, ferm, st	reet, factory,			28f. Location (Str City or Town	reet and Numb , State)	er or Rural Rou	te Number,
Hospit	within 24 hours a To the Funeral D completely filled i	edicai (29a. Certifier (Check only one)	nar: On the ba	best of my know asis of examinet ner steted.	wledge, deet tion end/or Ir	th occurred et	the tin	ne, dete end piece, pinion, deeth occurr	end due to the ce red et the time, de	use(s) end me ite end plece, e	nner as steted. and due to the o	œuse(s)
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			30. Name and address of person who co	PAAC	4.0	831) Che	rr	4 lane,				
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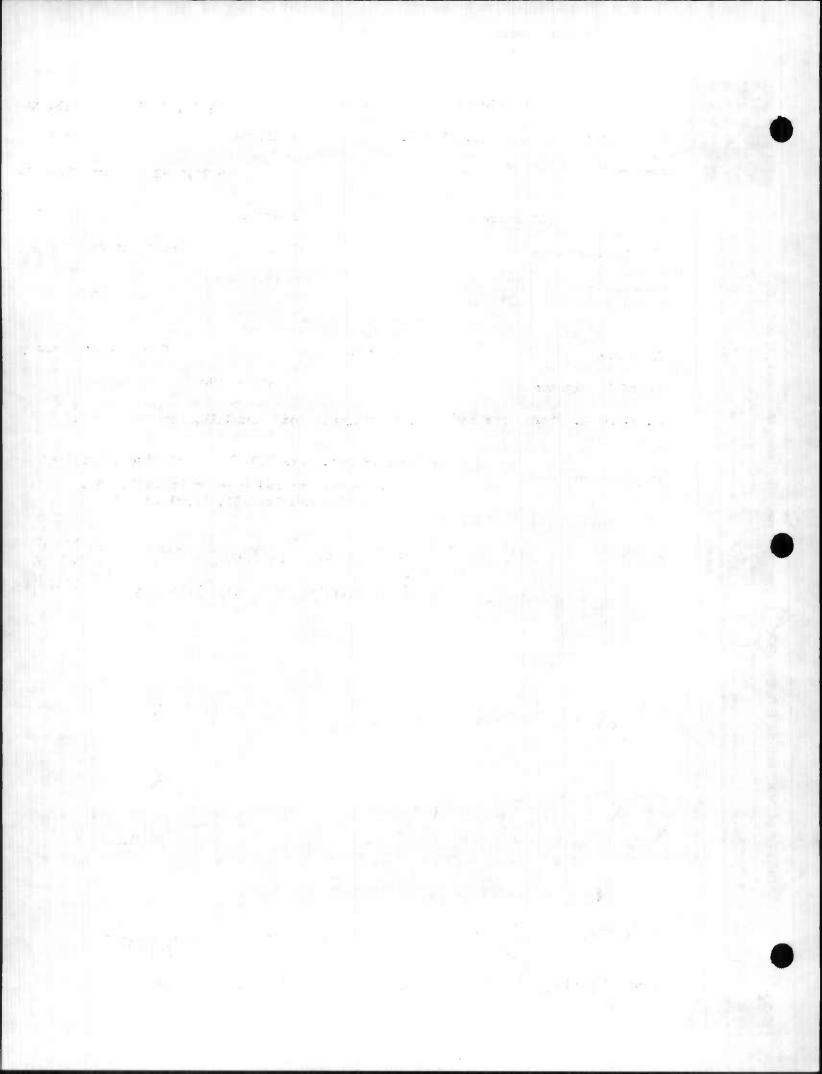
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name /First Middle Last) **Physician** Geraldine Staron July 14, 1998 6:34 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** N/A Johns Hopkins Bayview Medical Ctr. Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🖾 F 230-20-8019 West Virginia Director May 26,1923 Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f ahow traumatic event, the Medical Examiner must be multied at Dundalk 1 ☐ Yes 2 XNo Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21222 6918 Ridgeway Road 2 should be filed within 72 hours aftar death and Mental Hygiene. 8 marked other then "natural", or Itams 23. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 200 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Sheet Metal Company Assembler 10 Years 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be Pauline Rohr Edward Pennington 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) permit. Pages 1 end 2 sh Department of Haelth and Important: If Itam 27 is m any injury or other traum page. Mr. Frank L. Staron/Husband Dundalk, Maryland 6918 Ridgeway Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ***Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 7/16/98 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Llews 7922 Wise Ave Dundalk, Maryland 21222 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Wg. inedita. Immediete Cause (Final disease or condition resulting In death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initieted events resulting In death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown þ 24b. Were eutopsy findings avelleble prior to completion of cause of death? 24a. Wes en autopsy performed? Completed page 2 s 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Be To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Aftar this funeral 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 1 Natural 5 Pending 1 Yes deeth. ≥ ☐ Accident Investigation 24 hours after deet Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At hom building, etc. (Specify) At home, farm, street, factory, office filled in by 4 Homicide Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted.

Medicaf Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fi edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number iss of person who completed cause of death (Item 23a) (Type, Print) Day, Year) JL 161998

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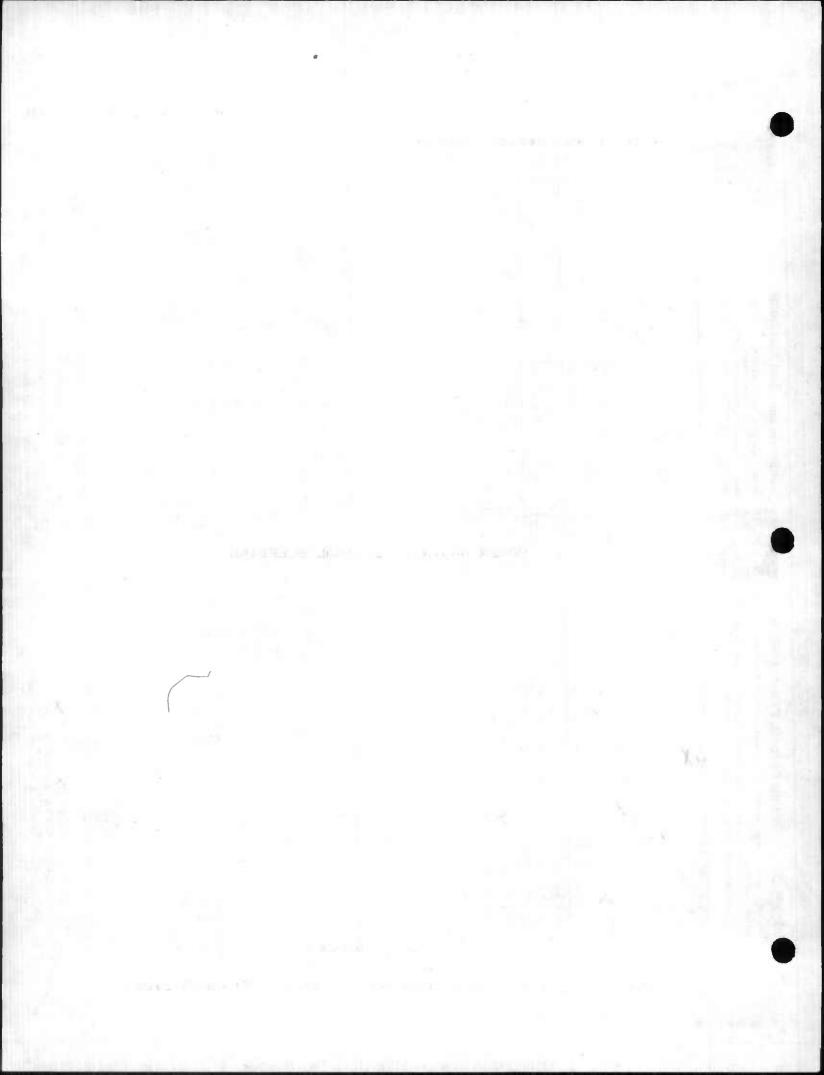
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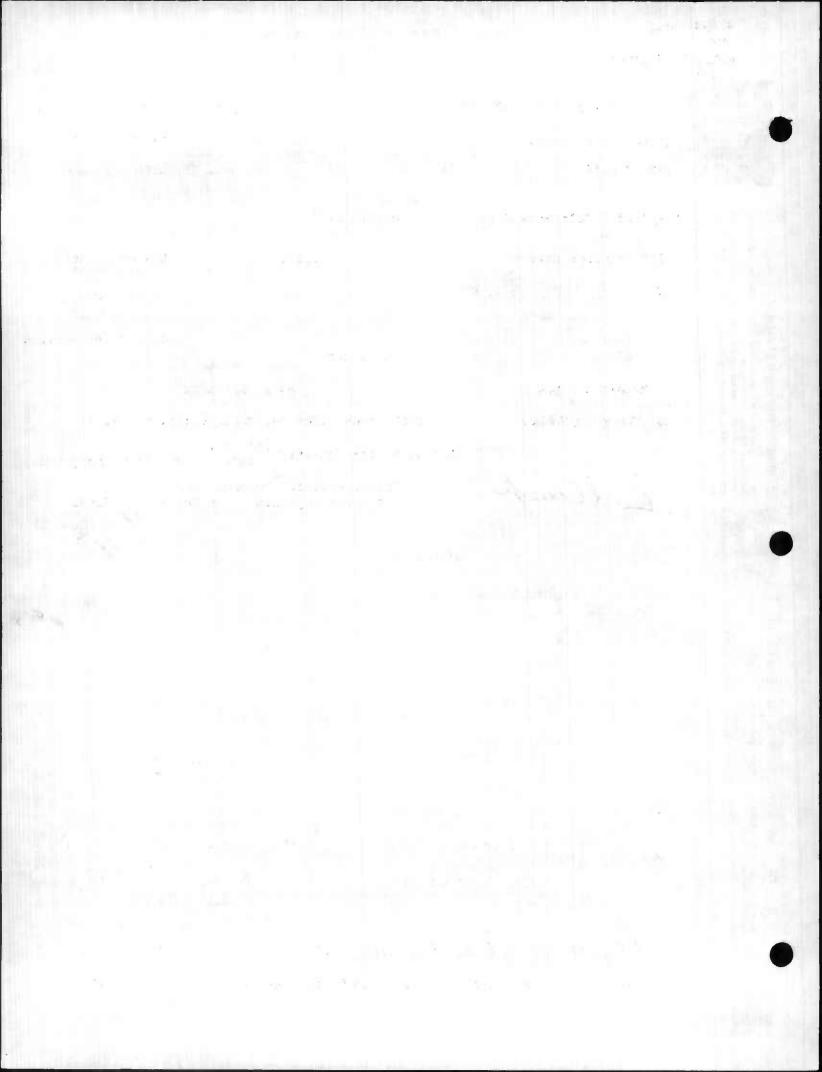
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Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Los	cation of Death 4	c. County of Death								
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h with the Maryland 3a or 28a-f show at be notified at al Director	10e. Street and Number 326 East Timonium Road 2	Code 1093		Citizen of What Cou	ntry?							
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Depart Depart Import Im	22. Name and Address of Facility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Ir 2134 Willow Spring Rd., Baltimore, Md. 2122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feitura. List only one cause on each line. Approximate Interval Boween											
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that the of the bed by the detached	ACUTE RENAL FAILURE		1 Yes	obably 4 Unknown								
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dical C	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred a control of the communication and mennar steted.	t the time, date and place, a in my opinion, death occurre	and due to the cause ed et the time, date a	(s) and manner as and place, and due to	stated. to the cause(s)							
A Supplied N	29b. Signatura and title of certifier 29c.	License number		Date signed (Month, 7-15-9)								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, M.D., 762Ø YORK ROAD,	TOWEON M	ARYLAND	21204								
State Registrar	31. Date filed (Month, Pay, Year) 32. Registrer's Signeture July 16 1998 32. Registrer's Signeture July Javidson Jandase	I DWDDIN III	עוותם ניוני	Som de Som Val ***								

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Month July 4:03 AM 1998 DOMINICK 7 J. TAMASSIA 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nema (If not institution, give street and number) UNION MEMORIAL HOSPITAL BALTIMORE If Undar 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Sacurity Number Birthplace (Stata or Foreign Country) 100 M 2□ F Months Deys Yrs 220054393 OCT 16,1920 MARYLAND Usual Rasidence of Decedant 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yas No ROSEDALE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 7522 USA BRIGHTSIDE **AVENUE** 21237 14. Race - Amarican Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Maritel Status 1V Yes 2 No If Yas, Giva Yaar or Detas: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2X No Specify: W II Specify: WHITE. 3X Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) STEEL MACHINIST 18. Mothar's Nama (First, Middla, Maldan Sumama) 17. Fether's Name (First, Middla, Last) ETTORE TAMASSIA LIA ROSSI 19a. Informant's Nama/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) ROSEDALE, MD 21237 Data 20c. Location - City or Town, State SHARON GLENN / DAUGHTER 7522 BRIGHTSIDE AVE 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition 1 Burlal 2 Cramation 3 Ramoval from State /15/98 4 ☐ Donation 5 ☐ Othar (Specify) BALTIMORE, MD GARDENS OF FAITH 21. Signature of Funeral Service Ciganace 22. Nama and Addrass of Fecility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resp shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Causa (Final disease or condition resulting in death) Dua to (or as a consaquanca of): yelonephritis Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated avants rasulting In daath) Last Due to (or as a consequence of) Brain Metastatic Due to (or as a consaquanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Steroid USE FOR BRAIN Cancer. 1 ☐ Yee 2 No 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Was an autopsy periormed? Cacheria 2 No 1 ☐ Yas 2 No 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ■Inpatiant 2 □ ER/Outpatient 3 DOA 28d. Dascribe how Injury occurred 28a. Data of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 1 ☐ Yas 2 ☐ No

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/Medical

Examiner

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Pages 1 and 2 should be filed within 72 hours after death \\
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28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

29a. Cartifiar া 🗑 Certifying Phyeician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifian

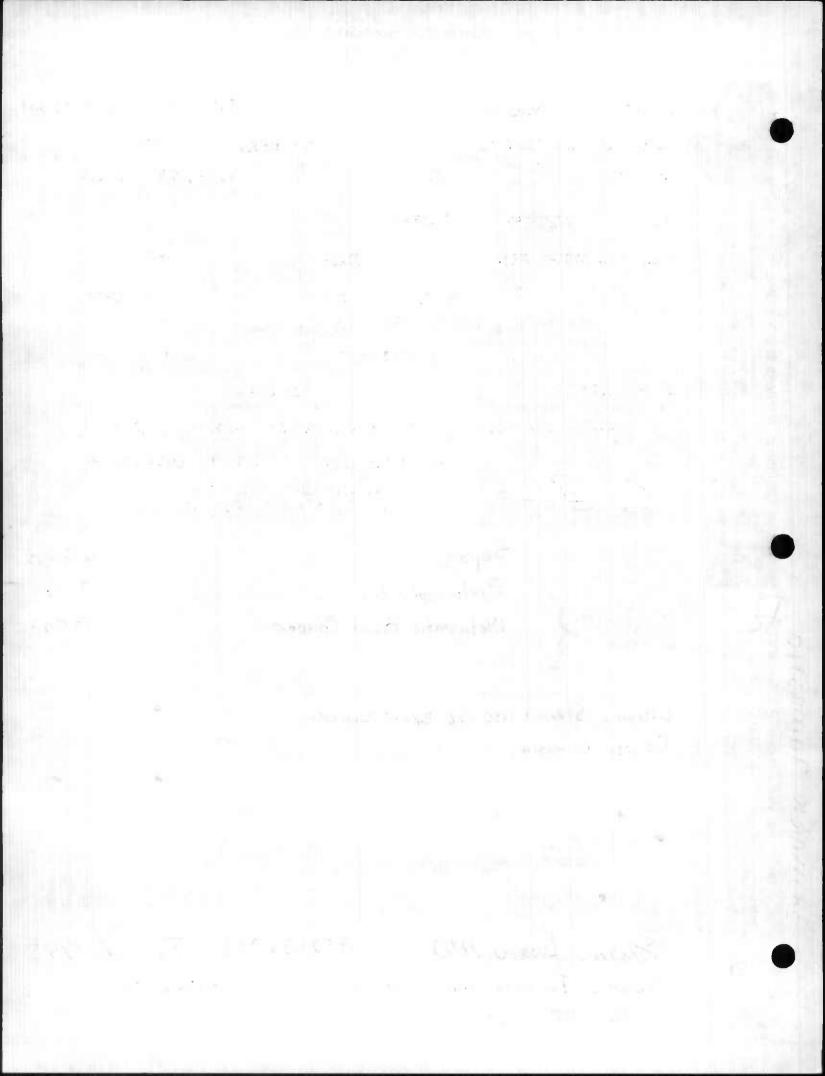
29d. Deta signed (Month, Day, Year)

30. Nama end addrass of person who complated causa of death (Itam 23a) (Type, Print)

ENSEN, DUSAN m.D. 200 E. University PKWY, Baltimore MD 31. Data filed (Month, Day, Year)

State Registrar 32. Magistrar's Signatura

To the 7



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month NORMAN RUI 7:45pm (2 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death SECOURS HOSPITAL BALTIMIKE BON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 214-03-3619 12 M 2□ F Months Days Yrs. Usual Rasidenca of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland altimor 1 Yes 2 No 10e. Street and Numbar 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Merital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. African American 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) STEEL WORKER 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Kober Annie 19a. Informant's Name/Relationship (Type, Print) (day9hter) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) Stone Ridge Balto, Md. 21208 20a. Method of Disposition 20b. Placa of Disposition (Nama of cemejery, crematory or other) /Date/ 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 □ Other (Specify) law 21. Signature of Funeral Service Licenses Funera ve. Ba that caused the daath. Do not enter the mode of dylng, such as cardiac or raspiratory arrest, Approximata Intarval Between Onset and Death tmmediate Cause (Final -acture Res DIVata diseese or condition rasulting in death) Pulmonare Obstructive Duease Sequentially list conditions, if eny, laading to immediata cause. Enter Underlying Cause (Diseasa or Injury that Initiated avants resulting in daath) Last Due to (or as a consequence of): Dementia Due to (or as a consequenca of) Dusage Rough Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Drunknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performad? completion of cause of death? 1 Yes 220 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f shifte Wedical Exeminer must be notiting

Funeral Director

Completed by

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the Maryland

Pages 1 and 2 should be filed within 72 hours after

other

Department of Health and Mental Important: If Item 27 is marked or any Injury or other traumatic eve

Baltimore, Maryland 21215-0020

Physician/Medicai The law requires that the death certifical certificate Be 10

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Completed

Medical Certification:

director, page 2 should al or Attending Physician: The setter death.

In Director: After this certificate filled in by the funeral

Division of Vital Records, P.O. Box 68769.

To the Hospital within 24 hours e To the Funeral C

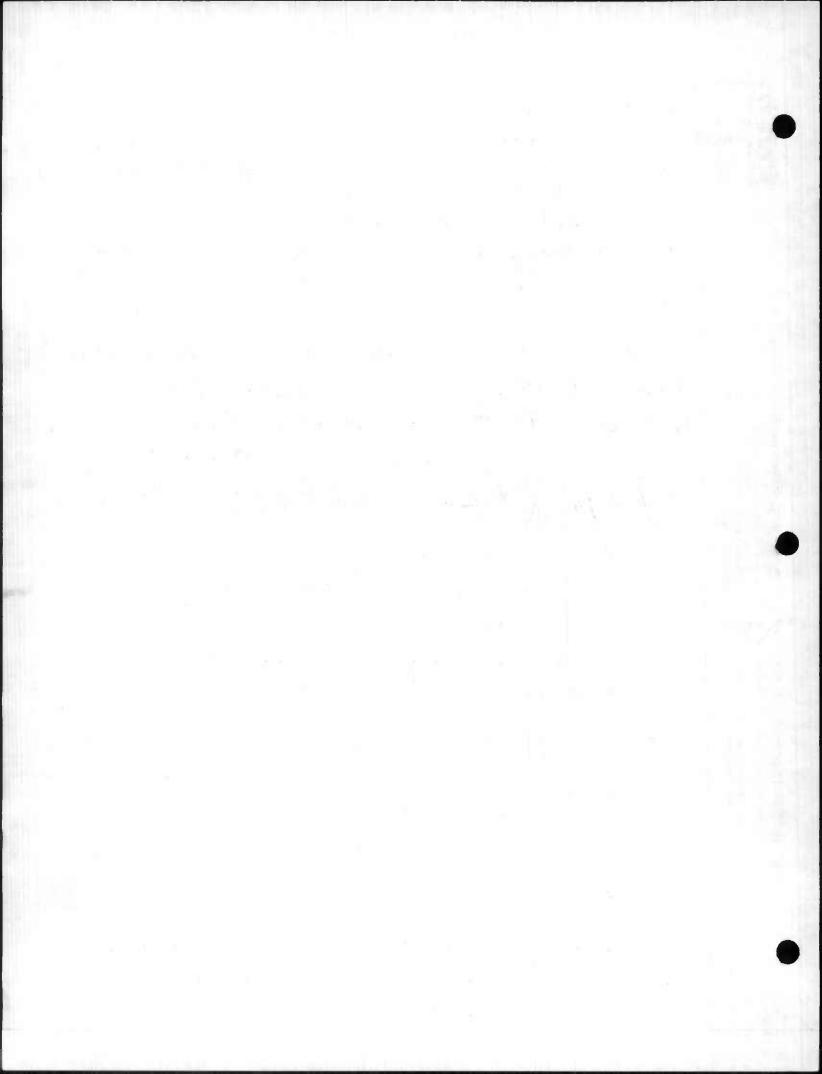
State Registrar 25. Was casa referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be datarminad 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Cartifian

12 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and manner stated. 29b. Signature and titla of certifiar 29c. License number 29d. Date signed (Month, Day, Year)

delefte a hours

30. Name and address of person who complated ceusa of death (Item 23a) (Type, Print)

W NOLTHERN PKLY RADCHIRSE M THOMAS RALTIMORE 4 000 32. Registrar sibignature 31. Date filed (Month, Pay, Year) 6 1998



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Degedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** AYNEROVSKIV UL 8:46 14 CONTO /Medical 4b. City, Town, or Location of Death 4c. County of Desth 4s Facility Name (If not Institution, giva straet and number) **Examiner** RANDALLSTOIN 15050 1TAL BALTIMORE NORTHWEST If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) if Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) **Funeral** Days 1 M 2 □ F 69 Yrs. Director 213-35-5342 JAN.16,1929 UKRAINE Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No REISTERSTOWN Director MD BALTIMORE 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 21136 UKRAINE 35 FARM GATE WAY Funeral death 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American indisn, Black, White, etc. 11. Marital Status 1 Never Married XXMarried altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media page. Elementery/Secondary (0-12) College (1-4or 5+) TAILOR TELLER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be VAYNEROVSKIY GOLDA ZEGELMAN ROMAN 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) REISTERSTOWN, MD 21136 35 FARM GATE WAY SONYA VAYNEROVSKIY (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Burial 2 Cramation 3 Removal from State BALTIMORE HEBREW 7/14/98 REISTERSTOWN, MD 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Feclity SOL LEVINSON & BROS., INC. PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD 23a. Part1. Enter the disease, or complication the used the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceutron each line. Approximate interval Between Onset and Death **Physician** /Medical tmmediata Cause (Final disease or condition resulting In deeth) INFARCTION ACUTE MYOCARDIAL HOUR Examiner Due to (or as a consequence ot) DISENSE EMAS CORONARY Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): edical Due to (or as a consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. MYOCARDIAL INFARCTION á 24b. Wera autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 2 3 No conficate 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatlent 3800A Other: 4 Nursing Homa 5 Residence 6 Other (Specify) To il di 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury st Work? Certification: 1 Satural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No or Attend after deatt Director: 6 Could not be detarmined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Hospital 24 hours a edical Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certiflei (Check only one) To the 4 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and III

OLD COURT RD

JULY 13 1998

PLANDAUS TOWN, MD 21133

State Registrar

39. Name and addless of person who completed ceuse of death (Item 23a) (Type, Print)

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32. Registrer's Signeture

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31. Date tiled (Month

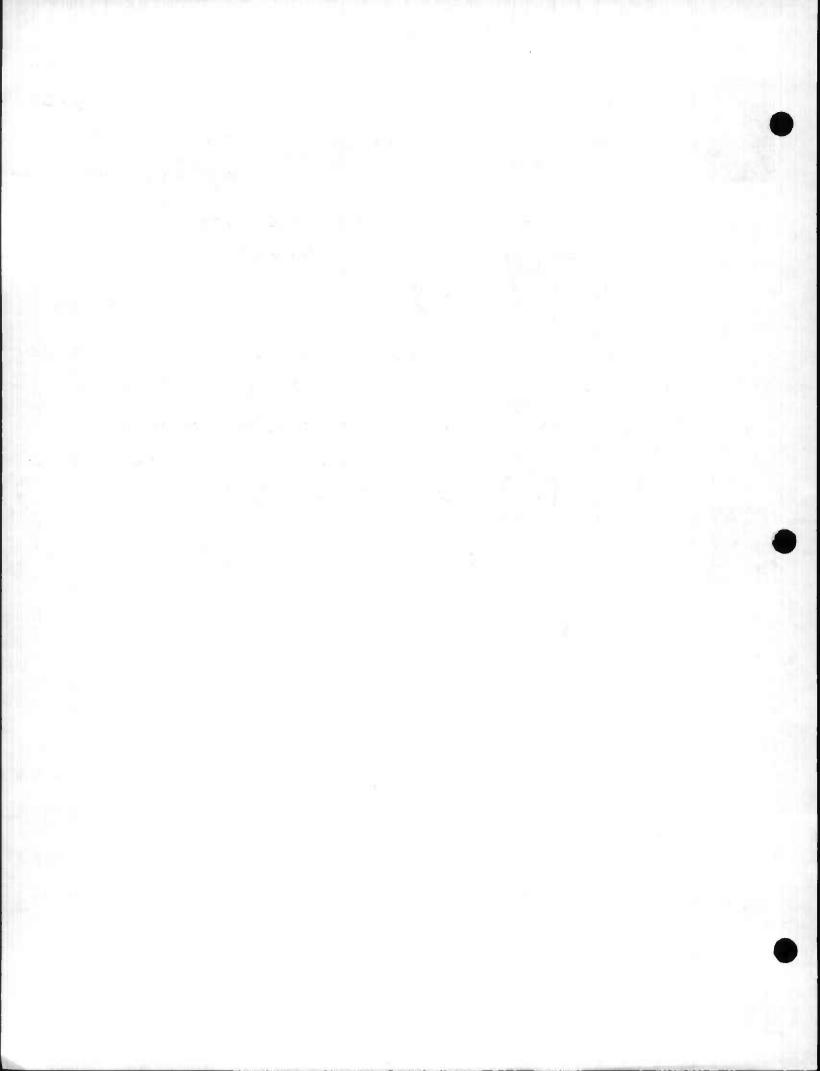
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State of Maryland / Department of Health and Mental Hygiene

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Exami		4a. Facility Name (If not institution, give	street end number)		4b. City, Town, or I	ocation of Death	4c. County of	of Death	
		IRVINGTON	KNOLLS	NURSING H	WE BAL	TI HORE		NIA	
Funeral	Г	5. Social Sacurity Number 6. Se	x. 7. Age (In vrs. I	ast birthday) If Unde	r 1 Year If Under 24 Hrs.	8. Data of Birth (Month, Dey,	Veerl	9. Birthpla	ca (Stata or Foreign
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ter dea	Funeral Director	11. Marital Status	Was Decedent Ever in U, Armed Forces?	S. 13. Was Dace if Yes, spe	dent of Hispanic Origin? (S city Cuban, Mexicen, Puert	pecify Yes or No- o Rican, etc.)		- Americe , White, et	
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altimore mit. Peges 1 g partment of He portant: If item violuty or others.		4 □ Donation 5 □ Other (Specify)	GA	RRISON FOR	REST CEME.	7-21-980	WINGS	S MIL	LS. MD.
		21. Signature of Funaral Service Licens	ее	22. Name a	nd Address of Facility PH H. BRO	TP	FUNER	201 1	Hame PA
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/Medical		Immediate Cause (Final disease or condition	Suvan	nous Col	type of t	onaure	Cance		3 Yu+
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0 5 5 8		27. Manner of Death	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe ho			
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D se se in participa di partici	Cer	4 - Homodo	building, etc. (Specify	,		Only of Town	, Siaio)		
Division or To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edicai	(Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinati	viedge, death occurred	at the time, date and place	, and due to the ca	use(s) and mar	nner as sta	ted. he cause(s)
the the plant	Med	one)	and manner stated.						
5 × 5 0		29b. Signature and titla of certifier	or Kirum		c. License number	29	d. Date signed		
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	1	30. Name and address of person who co	empieted cause of death (item			1			
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511		Fm 206 31. Date filed (Month, Day, Year)	8 2 / A		street	Baction	we m	ed:	2120



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 1998 10:03PM **Physician** DAVID RANDALL WENGER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Baltimore Hospital C 7. Age (In yrs. last birthday) enter If Under 1 Ye osedale tranklin Square If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months 1X M 2□ F 555-60-2081 Director 7/22/42 WEST VIRGINIA 55 Usual Residence of Decedent 10c. City. Town or Location 10d. inside City Limits 10a State 10b County r 28a-f show 1 ☑ Yes 2 ☐ No Director N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "natural", or items 23s or USA Funeral 5932 MARLUTH AVENUE 21206 12. Was Decedent Ever in U,S. Armed Forces? 1 X) Yes 2 □ No If Yes, Give Yeer or Dates: 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. p 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th GRADE INSPECTOR AIRCRAFT INDUSTRY 18 Mother's Name (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middle, Last) EARL S. WENGER ETHEL C. PUFFENBARGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mportant: If item 27 any injury or other tr ANNA M. WENGER WIFE 5932 MARLUTH AVENUE BALTIMORE, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/17/98 COCKEYSVILLE, MD DULANEY VALLEY MEM. GAR. 22. Name end Addrass of Facility JOHNSON FUNERAL HOME, P.A. 21286 Approximate Interval Between Onset and Death 8521 LOCH RAVEN BLVD. TOWSON, MD enter the mode of dying, such as cardiac or respiratory arrast, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cades on each line. **Physician** Immediata Cause (Finat diseese or condition resulting in death) /Medical · Atherosclerotic Cardiovascular Disease Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician for use as the burta that initiated events Due to (or es e consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy periormed? Completed completion of cause of death? 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA : After this 27. Manner of Death 28b. Tima of 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Natural 2 Accidant 5 Panding investigation 1 Yes 2 No Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homlcide n 24 hours the Funeral Dire edicai 29a. Certifier Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and dua to tha cause(s) and manner as stated. Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one)

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Division of Vital Records, P.O. Box 68788

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State Registrar

31. Date filed (Month, Day, Yaar) 1111, 161998

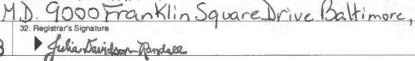
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30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

29b. Signeture end title of certifier

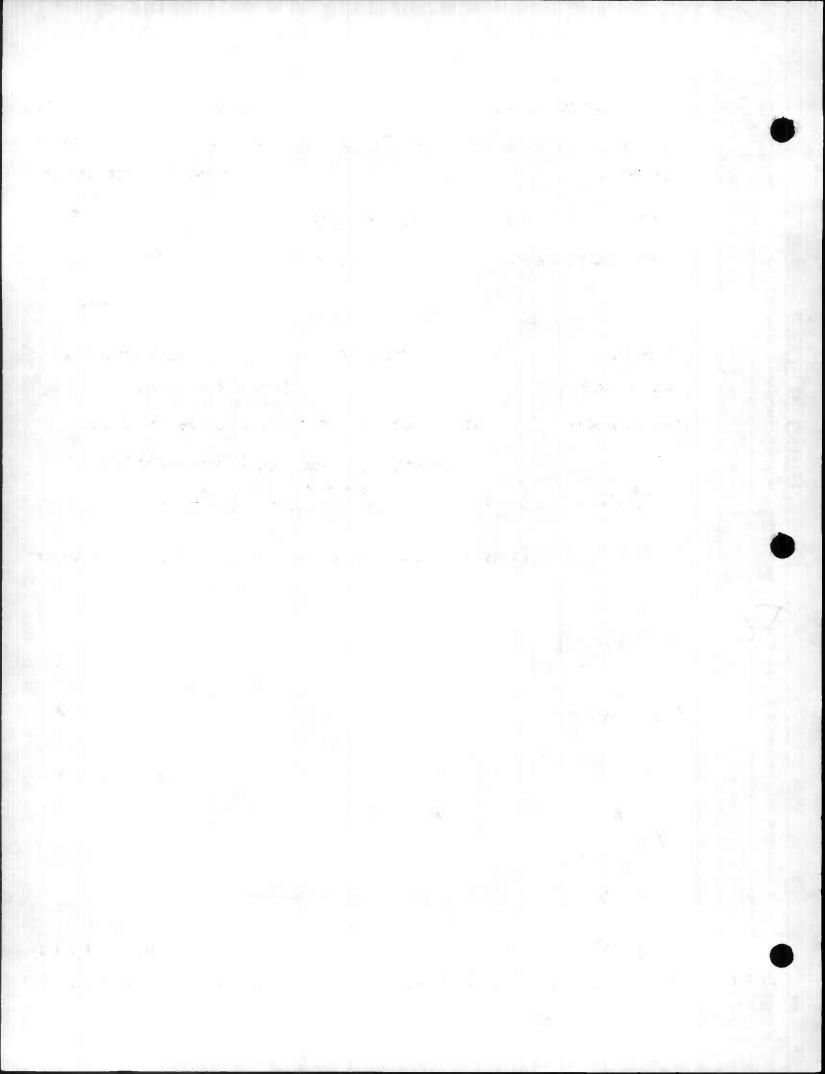
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29c. License number

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 21864

## Cally Name (if not institution, give street and number) PRINCE GEORGES COUNTY HOSPITAL FRINCE GEORGES COUNTY HOSPITAL Social Security Number 10 Stocial Security Number 11 M 30/5 7, 7/49 (in yes, last britinday) Hunder 1 Year Hunder 24 Hrs. Detent of Briting 24 Hrs.	al _		ne (First, Middle,	, Last)						T. I'A	2	Data of Dec		V	3. Time of Dea
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MD PRINCE GEORGES 10e. Street and Number 3326 MEMPHIS LANE 11. Meritel Status 11. West Becedent Ever in U.S. Armed Forces? 11. Yes 2 (2No Horse) 11. Yes 2 (2No Specify) (Specify Yes or No-Black, White, acc. Specify) 11. Yes 2 (2No Specify) 12. Yes 2 (2No Specify) 13. West Decedent of Hispanic Origin? (Specify Yes or No-Black, White, acc. Specify) 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 16. Kind of Business/Indust 16. Kind of Business/Indust 16. West of done during most of working 16. West of done during most of working 16. Work 19th entired 16. Kind of Business/Indust 16. Kind of Business/Indus 16. Kind of Business/Indust 16. Kind of Business/Indust 16. Kind	н					10c. City. To	wn or Loc	cation							10d. Insida City Li
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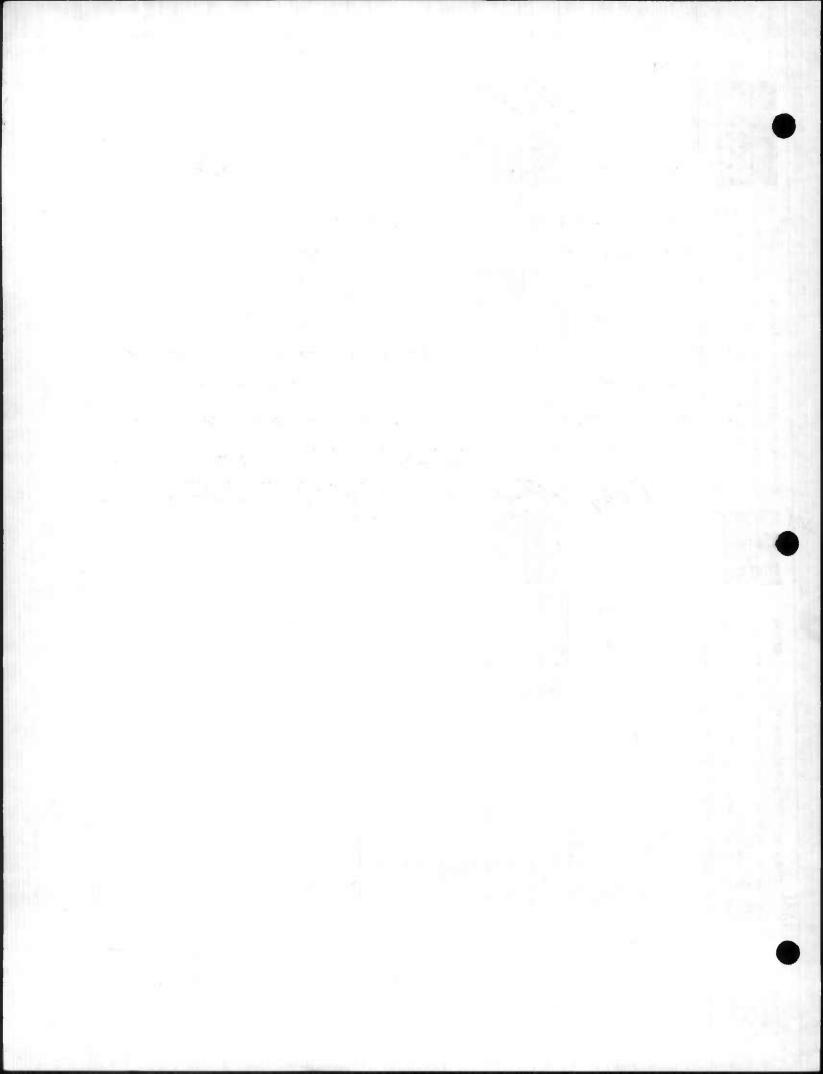
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State of Maryland / Department of Health and Mental Hygiene Amend: #29d Per MD Film G761 7-16-98RC Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month **Physician** 23:25 WALTER E. WILLS JULY 1998 /Medical 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE ST. AGMES If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 10/01/1914 6. Sex ★ 2 F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 216-01-4352 83 Yrs. Director MARYLAND Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yas 2 No Director BALTIMORE CATONSVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6 the Medical Examiner must be 207 ROSEWOOD AVE. 238 21228 U.S.A. (0) Harns 2 Funera 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 11. Marital Status Armed Forces?

1 □XYas 2 □ No
If Yes, Give
Year or Dates: 72 hours after 1 ☐ Never Married 2 [X Married 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grada completed) should be filed within 7; ind Mental Hygiena. Elemantary/Secondary (0-12) Collage (1-4or 5+) 10 MAINTENANCE FOREMAN STATE OF MARYLAND Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mothar'a Nama (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit ment of Health and Mental Hant: If item 27 is marked oth jury or other trsumatic sven Be GEORGE WILLS BLANCHE POTTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) DORIS WILLS/WIFE 207 ROSEWOOD AVE. CATONSVILLE, MD 21228 20b. Placa of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata BALTIMORE-WASHINGTON permit. Page Department of Important: If any injury or once. LAUREL , MD 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY 22. Nama and Address of Facility
STERLING ASHTON FUNERAL HOME, INC. 21. Signature of Funeral Sarvice Licansee Hosto 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physiclan** /Medical Immediata Cause (Final PNEUMONIA 5 days disaase or condition rasulting in death) Examiner Dua to (or as a consequenca of): Examiner COPD loyears physician and the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in daath) Last Due to (or as a consequenca of): ADFNOCARCINOMA LARYMEEAL 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown signed t þ Records, 24b. Wera autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed page 2 s 1 Tyes No No 1 ☐ Yas 2 ☐ No certificate Vital director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1X Yes 2 No o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation 1 Natural 1 Tes 2 □ No death. 2 Accident Director: 6 Could not be datermined 3 Sulcida 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 4 Homicide • Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piaca, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the F To the within 2 29b. Signature and title of cartifier 29c. Licansa number 29d. Date signed (Month, Day, Year) ulen M.D. 11701 1998 30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print) 0+ 900 CATON AVE BALTIMORE MD 21228 Dr. F. MICULESCU 32. Regillrar's Signature
Guna Dayldson-Randalle 31. Date filed (Month, Day, Year) State JUL 161998 Registrar



Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

To Be Completed by Funeral

Medicai Certification: To Be Completed by Physician/Medical Examiner

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at 8028.

Physician

/Medicai Examiner

Baltimore, Maryland 21215-0020

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To the Hospital or Attending Physician: The lew requires that the death certificate betweed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dateched for use as the buriel-transit

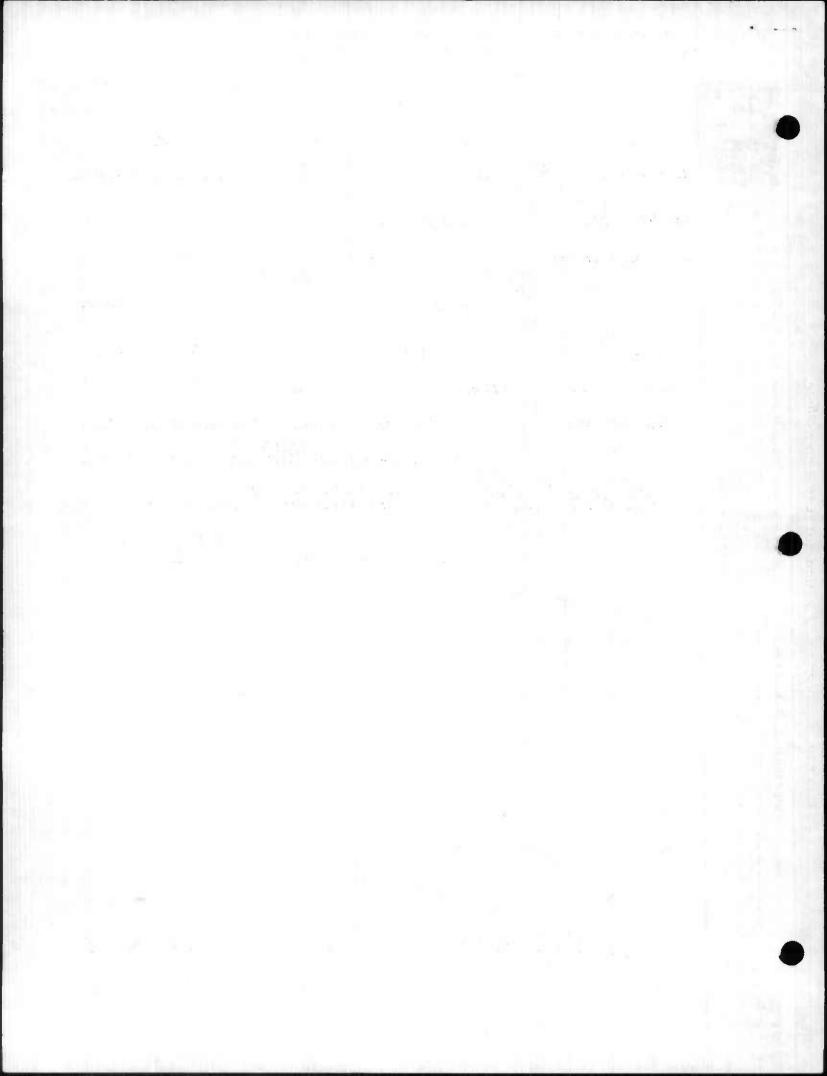
State Registrar

31. Data filed (Month, Day, Year) JUL 1 6 1998

Ellon Pizar, HD

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)





Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Year Month **Physician** July 10, 1998 Freda R. Zielski 1:13 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown If Under 24 Hrs. 8. Date of I Hours Min. (Month, Robosson Court Nursing Home Baltimore If Undar 1 Year 5. Social Security Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 6. Sex Days Months 1□M 2⊠F Yrs. June 3, 1914 212-01-1941 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Randallstown Maryland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21133 3922 Noyes Circle Apt. 1 U.S.A. Funeral 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐ Yes 2 ☑ No Yes, Give 1 Never Marriad 2 Married 1 ☐ Yes 2K No Specify: Specify. by 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Admissions Office Church Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Veronica Matuszak Max Golanski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randallstown, MD 3922 Noyes Circle Apt. 1 Mrs. Nancy Frye 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 7/14 Holy Cross P.N.C.C. Cem Dundalk , Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Loring Byers Funeral Directors, Inc. 8728 Liberty Road 21133 Randallstown, MD Approximata Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediate Cause (Final . Acute Coronary Thrombosis zmontus disease or condition rasulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown by 24b. Were autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 HNO Be 25. Was case refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 ☐ Accident 6 Could not be determined 3 Suicide Location (Streat and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate per Records, P.O. Box 6876 signed by the eld be detached f been si hes s certificate has director, page 2 Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director. F. To the Hosp within 24 ho To the Fune completely f

Funeral

Director

Hygiene. yther than "natural", or frems 23a or 28a-f ahow ent, the Medical Examiner must be nothlied at

marked other

. Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 is marked oth jury or other traumatic even

permit. Page Department of Important: If any injury or

Physician /Medical

Examiner

the Meryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0020

29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number

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31. Date filed (Month, Dey, Yeer) State JUL 1 6 1998 Registrar

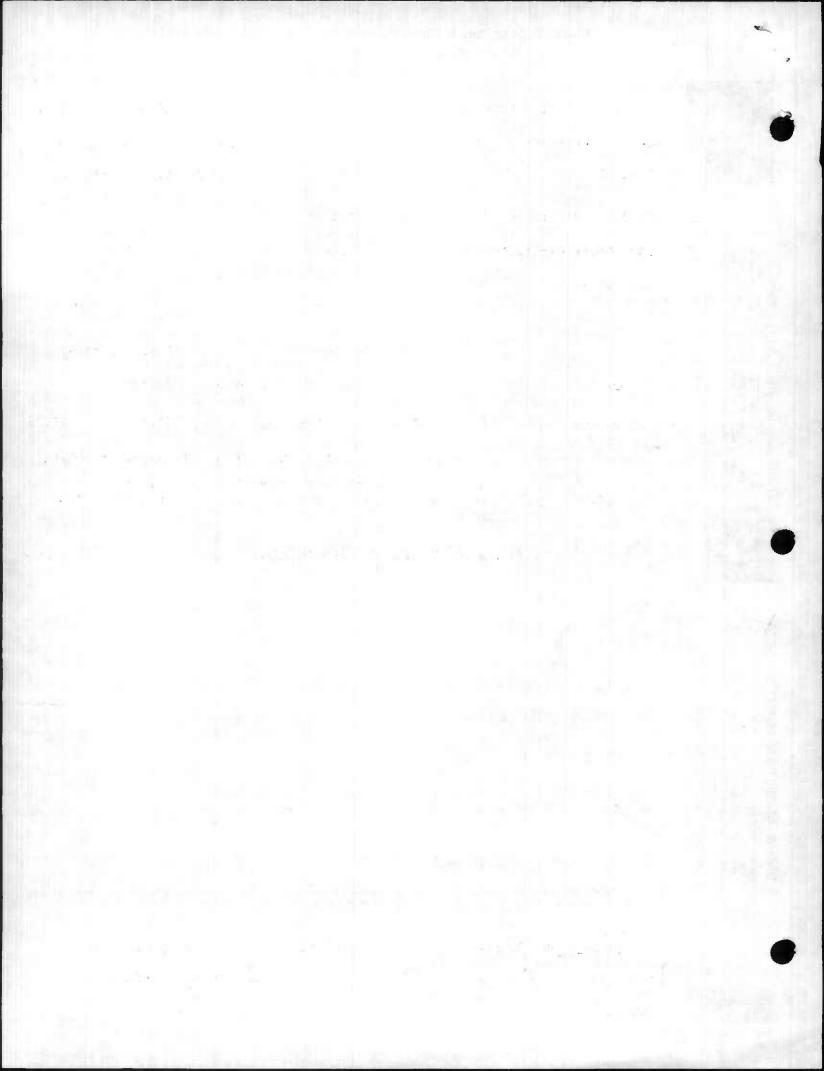
30. Name and address of person who

D6 borah

eted cause of death (Item 23e) (Type, Print)

32. Registrer's Signature

145931



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death **Physician** Month William Leroy Brooks Jr. June 30, 1998 9:45pm /Medicai 4a. Facility Neme (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Marriner Health Care Center Is Under 1 Year | If Under 24 Hrs. Prince Georges 5. Social Security Number 8. Dale of Birth (Month, Day, Sept 26 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country)
 MD Funeral 212-22-9144 1 M 2□ F Days Hours 73 Yrs. Director Usual Residence of Decedent deeth with the Maryland 10e. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits items 23a or 28a-f short ner nast be notified at Md. Prince Georges Greenbelt Funeral Director 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7952 Lakecrest Drive 20770 USA 12. Was Decedent Ever in U.S. Armed Forces?

19 19 50 - 19 50 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black. White, etc. Peges 1 and 2 should be filed within 72 hours efter 1 Nevar Married 2 ☐ Married 21215-0020 ò Completed by 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White "natural" 15. Decedent's Education 16a. Decedent's Usuai Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) x-ray technician health care other traumatic event, 17. Fether's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be fi Depertment of Health end Mentel F Important: If Item 27 Is marked ott any Injury or other traumatic ever Mentel William L. Brooks Sr. Helen K. Frey 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) June Allen (cousin) 1640 Liberty Rd. Eldersburg, MD 21784 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 7/6/98 Baltimore, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL (Box 195) Haig Sykesville, MD 21784 (410)-795-1400 23a. Pert1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Physician /Medical · ACUTE CEREBROVASCULAR ACCIDENT Immediate Ceuse (Finel 3 weeks disease or condition resulting in death) Examiner ATHEROSELE ROSIS Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enler Underlying Cause (Disease or Injury that Initiated avents rasulting in death) Last Due to (or es e consequence of): attending physician and Box 68760. Physician/Medical Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Right Lemiplegia. Aphasia 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Ware autopsy findings eveilable prior to completion of ceuse of death? 24a. Was an eutopsy performed? STROKES . INSULIN DEPENDENT mellitus 1 Yes 2 No After this certificate DIAbetes Be 25. Was case referred to medicel exeminer? 26. Plece of Death (Check only one) 20 1 Yes 2 No Other: 4 Nursing Home 5 Residance 6 Othar (Specify) 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Yeer) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

Division of Vital Records, or Attanding Physician: death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signeture end little of certifier ATTENDING 29c. License number D16200

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and menner stated. 29d. Dale signed (Month, Day, Year)

mon who completed cause of deeth (Item 23a) (Type, Print)

720-CMAIDEN Choice LA., CATONSville, MD 21228 . W. M. MACHIRAN

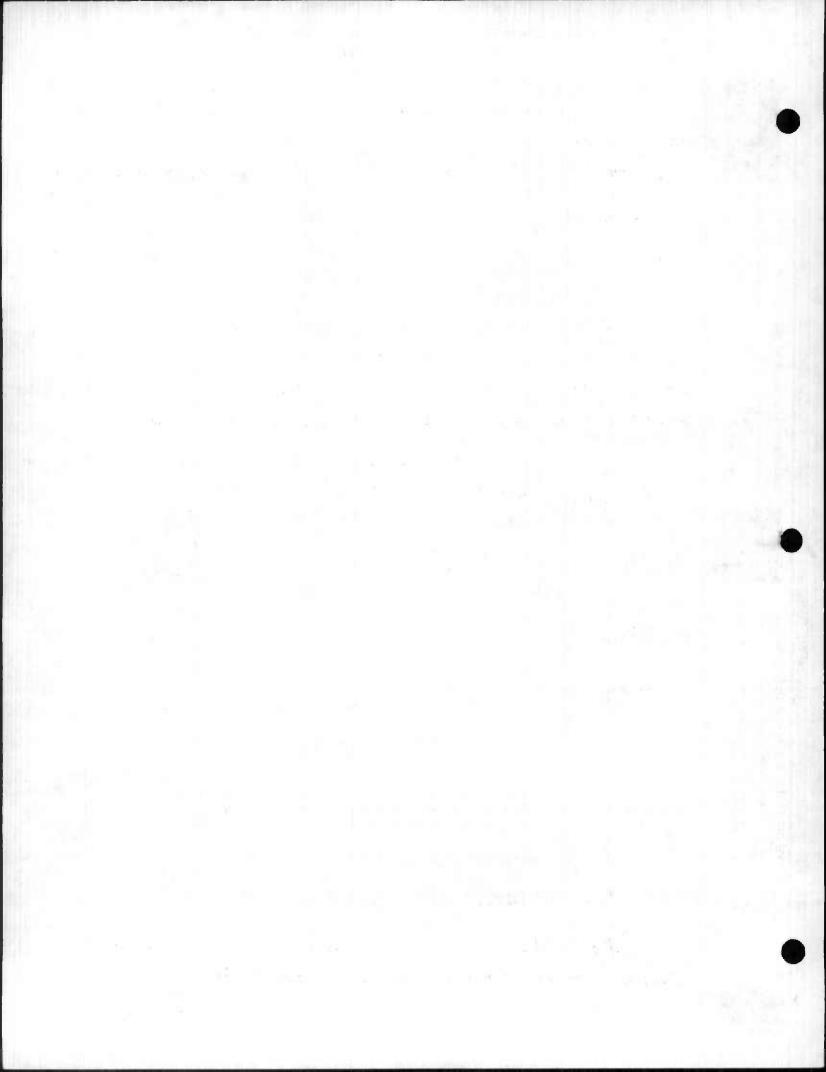
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

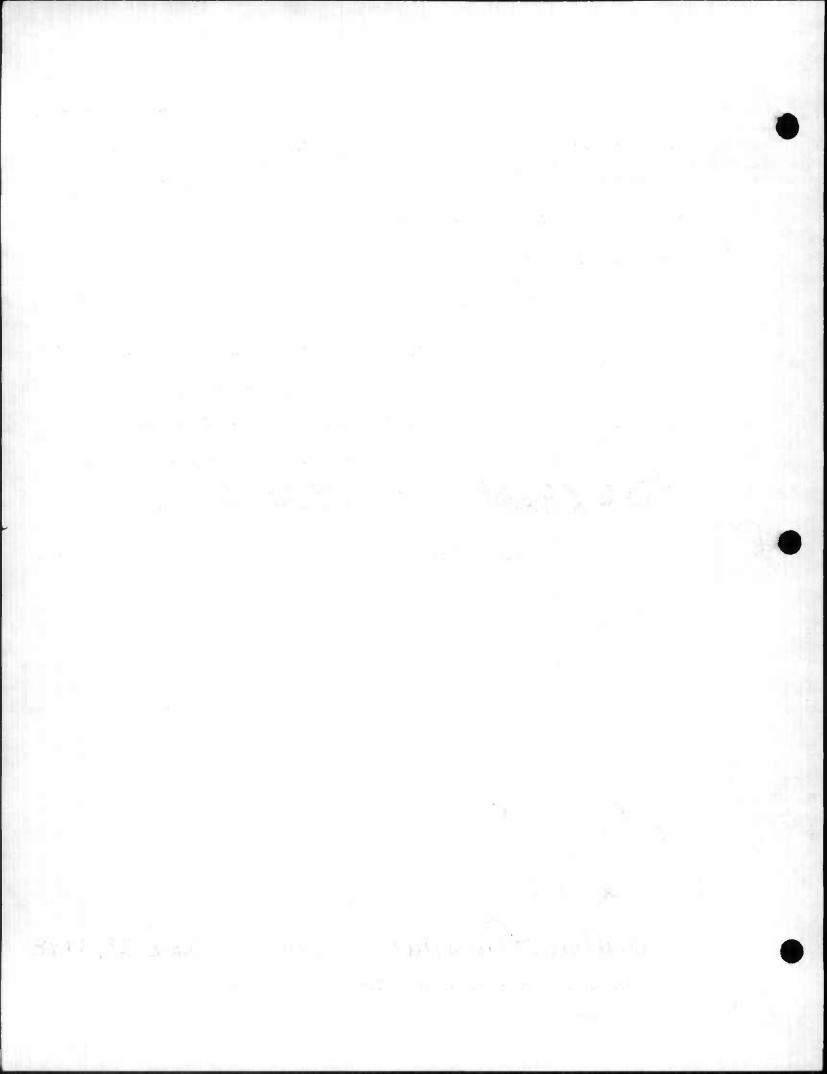
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xamine	er	4a. Facility Nama (If not institution Calvert Memori					4b. City, Town			4c. County	of Death alver	+
ineral rector		5. Social Sacurity Number 216-30-4577			s. last birthday 84 Yrs.	Months Dey	ar If Undar 24	4 Hrs. 8. Min.	Defe of Birth (Month, Day, Ct. 7,	Year)		lace (Stete or F
M til		Usuel Residence of Decedent 10e. Stete 10b. County		10c. C	City, Town or I	Location					1	Od. Inside City
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23a or 28 ust be no	rai Director	10e. Straef and Number 9726 Ridgev	iew Drive			10f. Zip Code 2073			10	og. Citizen of V US		fry?
	by Funeral	11. Maritel Status 1 □ Nevar Married 2 □ Marri 3 ◯ Widowed 4 □ Divorced	12. Was Decer Armed Ford 1 Tyes 7 If Yes, Give Year or Da	ces? 2 No a	U,S. 13	. Was Decedent of if Yes, specify Co		n? (Specify Puerto Rice	Yes or No- an, etc.)	Blec	e - Amaric k, White, o	etc.
r then "natural", Tre Medical Exp	Completed	15. Decedent (Specify only highes Elementery/Secondary (0-12)	s Education t grade complatad) College (1-	4or 5+)	16e. Dec (Giv life.	edent's Usuel Occ re kind of work dor DO NOT use reti Cook	upation e during most o red)	of working	1	Restau		ĺ
5 6	Be	17. Fether's Name (First, Middle,	,					s Name (Fi		feiden Sumem		
marke	2	William H 19e. Informent's Name/Reletionsl		Jones	401 141		Lena		Victo			sell
_ 3		Geraldine E. Gr		er		ling Address (Stre Box 708			MD 207		Stete, Zip	Code)
Important: If Itam 27 is any injury or other tra once.		20a. Method of Disposition 1 \(\overline{\text{Densition}} \) 4 \(\overline{\text{Donetion}} \) 5 \(\overline{\text{Other}} \) (Signature (Signature))		late		position (Name of ematory or other p	/ece)		Dete 2	Oc. Location -		
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g physician and as the burial-transit	Medicai Examiner	resulting in death) Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b	Due to ((or es a conse	equence of):		110	OR E			3 dc
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State of Maryland / Department of Health and Mental Hygiene

		1 December 1 Norma (First Afficial)	Inthe America		Cer	tificate d	of Death		leg. No.	3 218	370
Physici	an	Decedent'a Name (First, Mid						2. Date of Dec Month	Dey	Year	me of Death
/Medic			Beulah Ma		Beitzel			July 2,			30 AM
Examir	ner	4a. Facility Name (If not institut		m <i>ber)</i>			4b. Clty, Town, o	r Location of Deeth	4c. County	of Death	
Section		788 Foxtown Roa					Accident		Garre	tt	
Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. lest birthday)	If Under 1 You Months Da			Year)	9. Birthplace (S Country)	tate or Foreig
Director		205-26-4088 Usual Rasidence of Decedent	1□ M 2□XF	64	l Yrs.	Nonino Bo	70 110010	June 15		Pennsylv	
show	-	10a. State 10b. Coun		10c. C	City, Town or Loc						de City Limit
28a-f sh	Directo	Maryland Garre	ett		Accide						Yes ZEIN
No.		10e. Street end Number				10f. Zip Cod			log. Citizen of	What Country?	
23a	ra .	788 Foxtown Roa					550		USA		
natural; or frems 23a or 28a-f show ricel Examiner mast be not fisd at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorce	If Yes Giv	rces? 2 X No	If	Vas Decedent Yas, specify C	of Hispenic Origin? (Cuban, Maxican, Pue No <i>Specify:</i>	Specify Yes or No- erto Rican, etc.)	14. Rad Bla Specifi	ee - American Indick, White, etc. White	en,
natural',	B	15. Deced	ent's Education		16a. Deced	ent's Usual Oc	cupation		16b. Kind of B	usiness/Industry	
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The American	Son	8			Housek	eeper			Motels		
al Hygia	Be	17. Father's Nama (First, Middle	e, Last)			_	18. Mother's N	ame (First, Middle,	Ma <i>ide</i> n Suman	ne)	
f Health end Mental Hygitem 27 is marked other other traumatic event,		Albert Hornberg	jer				Lizzie	e Landis			
is m		19a. Informant's Name/Ralation			19b. Mailin	g Address (Str	eet and Number or F	Ru <i>ral Rou</i> ta Numbe	r, City or Town,	State, Zip Code)	
Health em 27 other tr		Delmar C. Beitz	el/husband		788 Fo	xtown I	Road; Acc:	ident, MD	21520		
		20a. Method of Disposition 1 → Burial 2 □ Cremation		Stete	Place of Dispos cemetery, crem	atory or other	plece)	Date		City or Town, Sta	
rtant		4 Donation 5 Other		0]			ade Cem	July6	Accid	ent, Ma	rylar
Depertment important: if any injury or once.		21. Signature of Funeral Service	1)0000		N	Newman	dress of Facility Funeral	Homes,	P.A.		
hysician		23a. Part1. Enter the disaase, shock, or hear the ure. Li	or complications that cast only one cause on e	ausad the dea ech lina.	ath. Do not ente	or the moda of	x 275; C dying, such as cardi	Grantsvi ac or respiretory ar	lle, M	1D 215 Approx Interva Onset	36. cimete Il Between and Death
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xaminer		resulting in deeth)	θ	Lund	or as a consequ	LINOW				d	years
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paga ; paga	S							1 🗆 Y	es 2 ANO	1 🗆 Yes	2□ No
	Be	25. Was case rafarred to medic examiner?					26. Place of Da	aath (Check only or	ie)		
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fter t	ü	27. Manner of Death 1 Natural 5 ☐ Pand	28a. Date o	f Injury h, Day Year)	28b. Time of Injury	28c. Ir	njury at Vork?	28d. Describe h	ow Injury occur	red	
or: A	cat	2 Accident inves	tigation	_		M 1	☐ Yes 2 ☐ No				
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	-	Zab. Signature and title of Cartill	track			2011				d (Month, Day, Ye	ar)
3		Droo	AVVV			104	0014 antsville		7-3	-98	
1	ſ	30. Name and address of person		of death (Ite	m 23a) (Type, P	rint)	1 11-				
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2		Douglas Kod	4 WD 12	A JACO	ler St,	(2 h	antsville	1 101	0613	36	

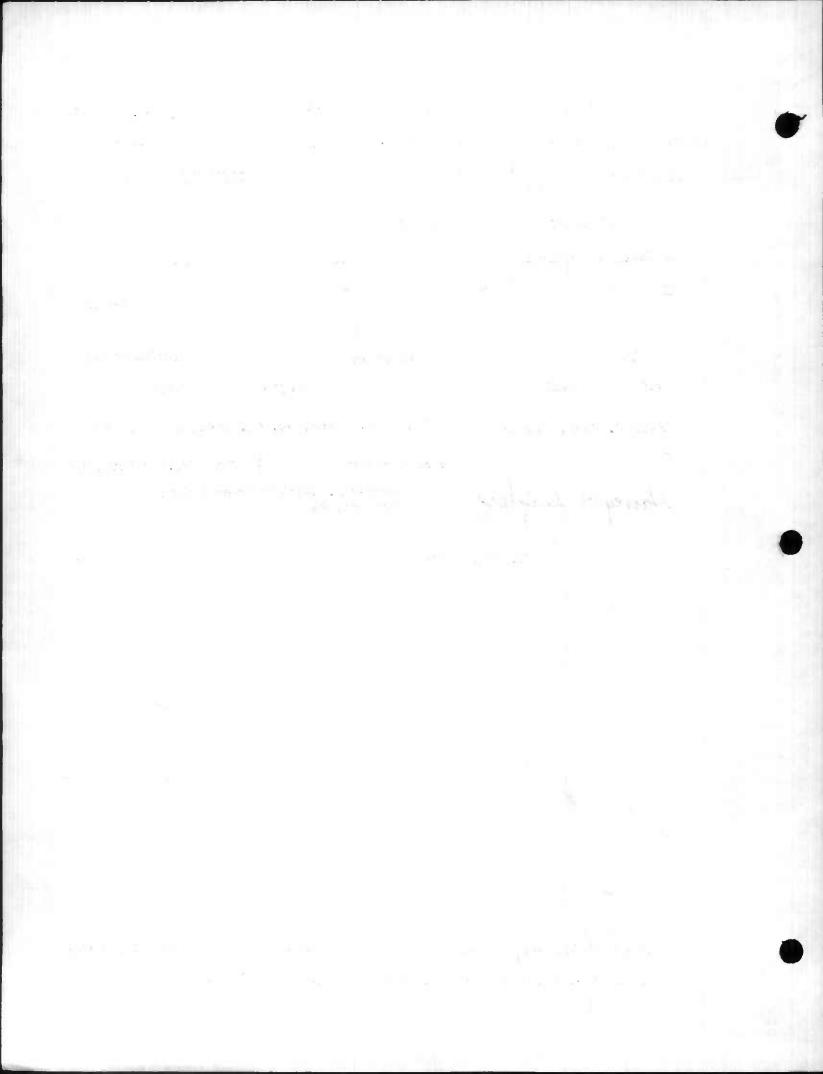


	1. Decedent's	Neme (First, Middle, I	Last)			rtificate of	20007	2. Deta of De	R eg. No.	- E-ma	3. Time of Deeth
Physician	ROBEI	RT ELLIS	BRYANT					Month	Day 1000	Year	10.25
/Medical Examiner	4a. Fecility Ne	ne (If not institution, o	give street end numb	ar)			4b. City, Town, or Lo	June 2		of Death	10:35 an
Examiner	Memor	lal Hospit	- 1				01				
uneral	5. Social Sacu			Aga (In yrs.	lest birthday	If Under 1 Yaar	Cumber 1 If Under 24 Hrs.	8. Date of Bir	Alle	gany	ce (Stete or Foreig
irector	212-24-	-5401 ca of Decedent	1 ∑ M 2□ F	69	Yrs.	Months Deys		(Month, De	y, Year) 22 1928.		ce (Stete or Foreig /) NIA
show ad at	10e. Stete	10b. County		10c. City	y, Town or Le	ocation				100	I. Inside City Limit
to lo	MARYLAN	D ALLEG	ANY	CUM	BERLAN	ND					1 Yes 2 No
or 28a-f s be notified Director	10e. Street end	Number				10f. Zip Code			10g. Citizen of V	Vhet Country	17
3a o		ALTIMORE A	VENILE			21	502		II C	۸	
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0 2 >		Merried 2 Married	Armed Force 1 Yas 2[If Yes, Give Year or Date	□No		If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Rican, etc.)	Specify	k, Whita, et WHI	
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other than vent, the M		11			TRUCKI	ER/CONSTR	LUCTION WO				RUCTION
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7 is marke traumetic TO		's Neme/Ralationship					t and Number or Rure				
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or of	20a. Method of		□Removal from Sta		em <i>etery</i> , cre	osition (Name of metory or other ple	ace)	Dete	20c. Location - RFD	City or Town	n, Stete
Jury jury	4 Donet	on 5 Other (Spec	cify)		Y GAP	VET CEME	TERY JULY	1, 199	8 FLINT	STONE	MD.
important: if item 2 any injury or other once.	21. Signature	of Funerel Service Lic	onsago -	1.		2. Neme end Addre	ess of Fecility AMS FUNER	AT HOME			
5 6 0		Sale Z.	Herritt				R STREET			VIAND	
	23e. Pert1. En shock, or	ter the disease, or co	mplications that causely one couse on each	sed the death	. Do not en	ter the mode of dyi	ng, such es cardiac d	or respiretory e	rrest,	. A	pproximeta ntarval Between
sician											Insat and Death
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igned by be detail								10	Yes 20 No	3 Proba	bly 4□Unkno
zate hes been signed by the ettendir page 2 should be detached for use Completed by Physician/N								24a. Was	an autopsy med?	eveil	eutopsy findings oble prior to
es b										of de	oletion of causa eath?
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rector, page 2 Be Comp	25. Was case a	eferred to medical					26. Place of Deeth	(Check only o	one)		
To To		21 No	Hospitel: Inpa	atient 2 🗆	ER/Outpetia	nt 3 DOA Ot	her: 4 \sum Nursing Ho	me 5□ Resid	denca 6 □Oth	er (Specity)	
= -	27. Manper of I	Death 5 ☐ Pending	28e. Dete of II (Month, I	njury Dey Year)	28b. Time o	f 28c. Inju Wo	ry at ::	28d. Describe I	now injury occur	ed	
ther this uneral di on: To	2 Accide	nt investigeti	ion				Yes 2□No				
or: After this the funeral cation: T			286. Place of	Injury - At ho etc. (Specify	me, farm, st	reet, factory, office	2.	28f. Location (a City or Tox	Street and Numb vn, Stete)	er or Rurel I	Route Number,
Irector: After this n by the funeral of rtification: T	3 ☐ Suicide	40									
rai Director: After this lied in by the funeral of Certification: T	3 Suicide			st of my know	viedge, deet	h occurred at the ti	me, dete end plece, opinion, death occurre	end due to the	ceuse(s) and ma	nner es stat and due to th	ed. ne cause(s)
• Funeral Director: After this letely filled in by the funeral of direction of direction of the forest of the fore	3 Suicide	Certifying F	Phyaicien: To the bes aminer: On the basis and menner	or examinat	ion end/or in	vostigation, at my t	,				
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he Funeral Director: After the pletely filled in by the funeral edical Certification:	3 Suicide 4 Homic 29a. Certifier (Check only	Certifying F	end menner	stated.		29c. Licans	sa number		29d. Date signe		ey, Year)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						,	(Certifica	ate of	Death		Reg. No.	8 2	1872
	Dhyala	00	1. Decedant's Name	(First, Middla, La	st)						2. Data of Dea		Yaar	3. Time of Death
1	Physici /Medi			ETHEL			T.		B	EAL	July	2. 19 ⁹		10:50 AM
	Examir		4a. Facility Nama (If	not institution, giv	e street and number)				1	4b. City, Town, or				
			The Memor	rial Hos	pital and	Medi	cal	Center	-	Cumberla	ind	A11	egany	
П	Funeral		5. Social Security Nu	mber 6. 5	Sax 7. Ag	ga (In yrs.		day) If Un	der 1 Year	If Undar 24 Hrs	8. Data of Birt	h		lace (Stata or Foreign
	Director		220-07-62 Usual Residanca of D	263	□ M 20 X F	84	Y	Month	s Days	Hours Min.	(Month, Da 11/11/		MD	(ry)
	yland		10a. State	10b. County		10c, Ci	ty, Town	or Location					10	Od. Inside City Limits
	Mar Ties	to	MD	Allegany	7	C111	mber.	1 and						1 X Yas 2 □ No
	r 284	Director	10e. Street and Numi			- Ou	mocr.		Zip Coda			10g. Citizan of V	What Coun	try?
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	death	Funeral	11. Marital Status	more Mye	12. Was Dacedant	Ever In U	J,S.			lispanic Origin? (S an, Mexicen, Puarl	pecify Yes or No-	USA 14. Rac	e - Amarica	an Indian,
21215-0020	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show doel Expander mark be notified at	by	1 Navar Married 3 □ Widowed 4		Armed Forcas? 1 ☐ Yas 2 ☐ If Yas, Giva X Year or Datas:				pecify Cubi	an, Mexicen, Puarl Specify:	o Rican, etc.)	Specify Specify	ck, White, a	
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Maryland	and Mental Hygiene. s marked other than aumetic event, the M	To	Levi	Bea	1					Aquila		Witt		
an	d 2 should th and Men 7 is marke traumatic		19a. Informent's Nan	na/Relationship (Typa, Print)		19b.	Mailing Addra	ss (Straat	end Number or Ru	ral Routa Numbe	or, City or Town,	State, Zip	Coda)
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Box	eath ce attendir for use	an			d									
	he a	Physician/I	Part II. Other algnific	ant conditiona c	ontributing to death b	ut not res	sulting in t	ha underlyin	cause giv	van in Part I.	23b. Dld t	obacco use co	ntribute to	the cause of death?
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		-	27. Manner of Death		28a. Deta of Inju (Month, Da		28b. Tir		28c. Injur Wor			now Injury occur		,
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S	or A after Direction	erti	4 Homicide	datarminad	building, at	c. (Spaci	fy)	.,	ory, ooo		City or Tow			
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	Sta Registr	_	31. Data filed (Month,	06 199	B PARTHED STATE	P) Braining	gi (yre							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 55 AM. ELINOR BELL CAMPER 07 98 3 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not Institution, give straat and number) 4c. County of Death Examiner DORCHESTER GENERAL HOSPITAL CAMBRIDGE DORCHESTER If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Data of Birth (Month, Dey, Year) 7. Aga (In yrs. lest birthday) Birthplaca (State or Foraign Country) 1□M 2XF Yrs 219-14-3979 89 APRIL 26,1909 MARYLAND Usuai Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No Director MARYLAND DORCHESTER EAST NEW MARKET

10f. Zip Code

1 ☐ Yes 2 X No

COMPUTER PROGRAMMER

20b. Place of Disposition (Neme of cemetery, cremetery or other place)

21631

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.)

10g. Citizen of What Country?

USA

16b. Kind of Business/Industry

MANUFACTURING

20c. Location - City or Town, State

Specify.

18. Mothar's Nema (First, Middla, Meiden Sumeme)

ELLA LOUISE DeMOTT

19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) P. O. BOX 245, EAST NEW MARKET, MD 21631

MD EASTERN SHORE VET. CEM. 7/6/98 BEULAH, MARYLAND

14. Raca - American Indian, Black, Whita, atc.

WHITE

Funeral Director

r 28a-f show notified at 8 the Medical Examiner must be therns 25a "natural", or

Funeral

b

Completed

2

10e. Street and Number

11. Marital Status

304 RAILROAD AVENUE

15. Decedent's Education (Specify only highest grada completed)

1 X Buriai 2 ☐ Cremation 3 ☐ Removal from Stata

1 Naver Married 2 Marriad

3 XWidowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

CYRUS EDWIN BELL

20a. Method of Disposition

19e. Informant's Name/Relationship (Type, Print)

JENNIE NOSSICK/NIECE

4 ☐ Donation 5 ☐ Other (Specify)

12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give

Yes, Give Year or Dates:

College (1-4or 5+)

Baltimore, Maryland 21215-0020 and Mental is marked Department of Health Important: If item 27 ò

> **Physician** /Medical Examiner

Physician/Medical Examiner þ Completed Be Certification: To

22. Name and Address of Facility
ZELLER FUNERAL HOME, P. O. BOX 207, Enter the disease, or 106 MAIN STREET, EAST NEW MARKET, MD 21631 r the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequenca of) Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Ky plo scelcosis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings PMAPMesis 24a. Was an autopsy available prior to completion of cause of deeth? performad? 1 Yes 2 Ho 1 ☐ Yes 2 No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Dey Yeer) 27. Menner of Death 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homlcide The Certifying Phyaician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and manner as stated.

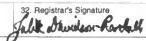
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) end manner stated. Cai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

7-6388

physician and the burial-transit The law requires that the death certificate be executed Box 68760. attending p for use es deteched f P.O. Division of Vital Records, or Attending Physician: this funeral death. 24 hours after deat Funeral Director: filled in by completely within 2 To the

> State Registrar

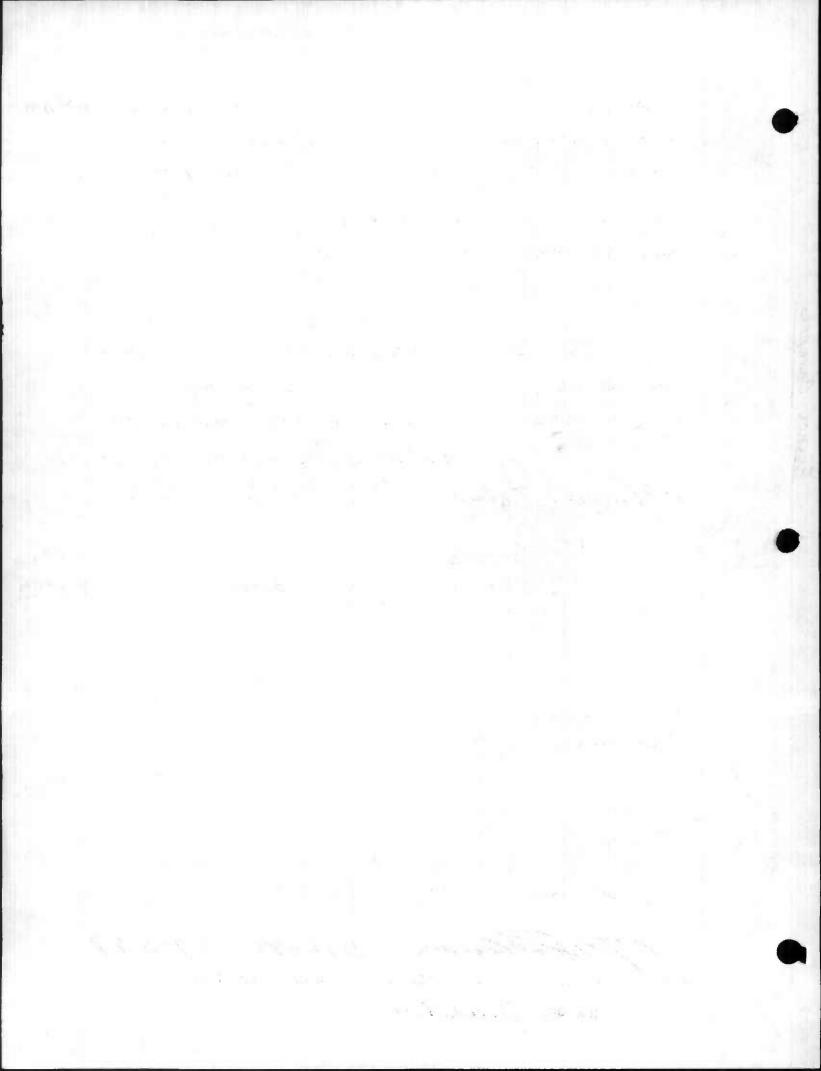
31. Date filed (Month, Dey, Year)



NICHAEL J. FADDEN, M.D., 302 COLLINS AVENUE, HURLOCK, MD 21643

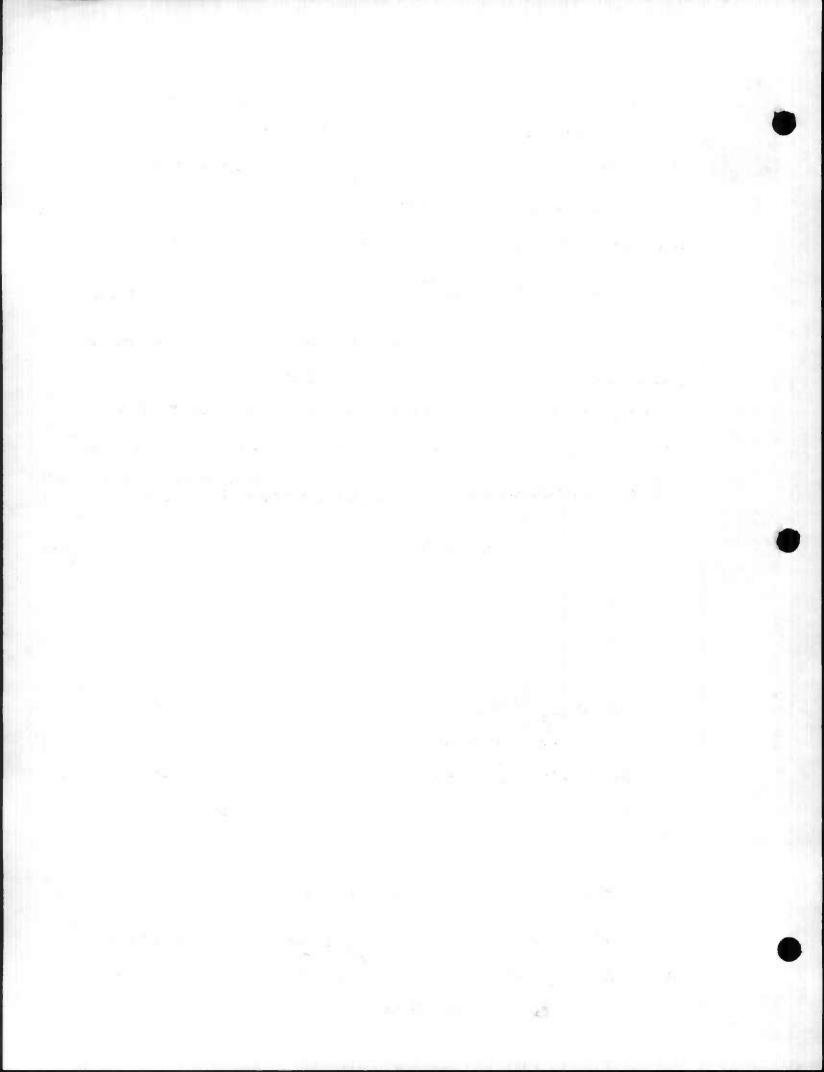
ableu do

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)



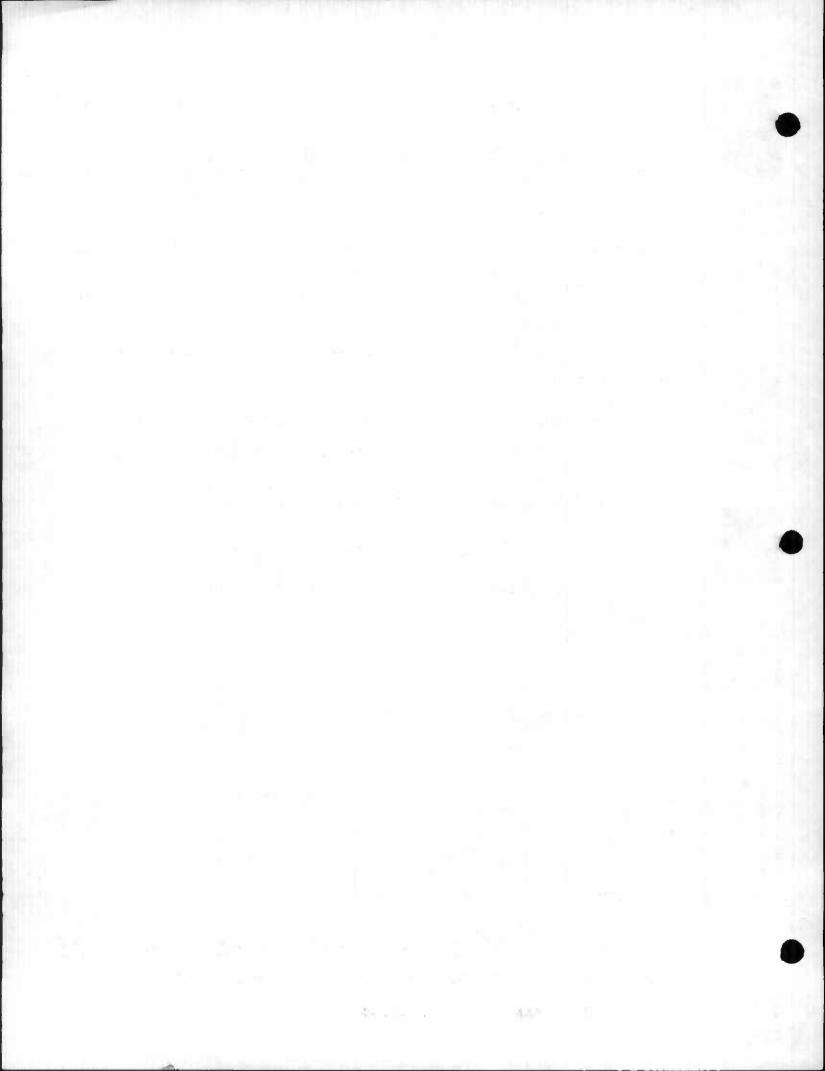
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

					-	tificate of	Death		Reg. No.	98	21874
Physici		1. Decedant's Nama (First, Middla, La Dennis O.	Cook					June 2	Dave	8 Yaar	3. Time of Death
/Medic Examir		4a. Facility Nama (If not institution, giv 14866 Bushy Park					4b. City, Town, or Woodbine	Location of Daa		ounty_of Daati	
Funeral Director	1	5. Social Sacurity Number 6. S 710–09–6407	ax X M 2□F 9	2 (In yrs. last b	virthday) Yrs.	If Undar 1 Yaar Months Days	If Undar 24 Hrs Hours Min		irth Py. Yell 90	9. Birth	npiaca (Stata or Foraigi untry)
e Maryland ta-f show	ctor	Usual Rasidence of Dacedant 10a. Stata Md. 10b. County Howard		10c. City, Toy Wood	wn or Lo	cation					10d. Insida City Limits 1 ☐ Yas 2 🛣 No
h with th	al Dire	10e. Street and Number 14866 Bushy Park	Road			10f. Zip.Code 21797			10g. Citiza USA	n of What Co	untry?
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Health and Merial Hygiene. Important: If Nem 27 is marked other than "natural", or Nems 23s or 28s-f show wall hiptry or other traumatic event, the Medical Examples must be notified at once.	by Funeral Director	11. Marital Status 1 Navar Marriad Married 3 Widowed 4 Divorced	12. Was Decadent E Armad Forcas? 1 ☑ Yas 2 ☐ N If Yes, Give Yaar or Datas:	19/2_		Vas Dacedant of life Yas, specify Cub	dispanic Orlgin? (an, Maxican, Pual Specify:	Specify Yas or N nto Rican, atc.)		. Raca - Amai Black, White Decify: bla	i, atc.
1215-C	Be Completed	15. Decedant's Ec (Specify only highast gra Elamantary/Secondary (0-12)	lucation da complated) College (1-4or 5-		(Giva I	ant's Usual Occu kind of work dona OO NOT usa ratira CK repai	during most of wo	orking		of Business/I	
Baltimore, Maryland 21215-0020 semit. Pages I and 2 should be filed within 72 hours elt sportment of Health and Ahental Hyglene. mportant: If item 27 is marked other than "natural", or my houry or other traumatic event, tra Medical Event. M.C.	To Be Cor	6 17. Fathar's Nama (First, Middla, Last) Charles Cook			ша	ck repar		ma (First, Middle Parker	1		1011
Mary ind 2 shou aith and N 27 is mer		19a. Informant's Nama/Relationship (Genevieve Cook (W	Type, Print) ife)	191	b. Mailin 4866	g Address (Stree Bushy F	and Number or Rear Ro.	lural Route Numi WOODD1N	ber, City or 1	29.799 z	ip Coda)
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Ball permit. Depend Import any inj		21. Signature of Funaral Sarvice Lican Pauge Haught				Nama and Addra	ess of Facility H 195 Syke				& Chapel
Physician /Medical Examiner		23a. Part1. Entar tha disease, or compands, or haart failura. List only immediate Cause (Final disease or condition resulting in death)	a. Der	nen fo	Å		ng, such as cardia	c or raspiratory a	arrast,		Approximata Interval Batween Onsat and Death 2 years
THECORDS, P.O. BOX 68/60, The lew requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the bunlet-transit	Physician/Medical Examiner	Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiated avants rasulting in death) Last	C	Due to (or as a							
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ACCORD le lew require has been si ge 2 should l	Completed	Pernicia	us Ane	mia				24a. Was	s an autopsy ormad?	a	Vara autopsy findings vallabla prior to ompletion of causa f death?
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his hy	Certification: To	1 Yas 2 No 27. Manner of Death 1 Natural 5 Panding invastigation 3 Sulcide 6 Could not be datarmined	28a. Data of Injury (Month, Day		Time of Injury	28c. Inju Wo M 1		28d. Dascribe	how injury o	ccurred	ral Routa Number,
Hospital or 24 hours afte Funeral Dir nety filled in	edicai Cei	Check only 2 Madical Exam	raician: To the best of Inar: On the basis of a	my knowledge	e, death	occurred at the ti	me, date and place	e, and dua to the	cause(s) ar	d mannar as	stated.
To the H within 24 To the F complete	Med	29b. Signatura and title of coopier	and mannar stat	ed.	10001111	29c. Licans	a numbar 3681		29d. Date	signad (Month	
		30. Nama and address of person who of	DM, NO				PROGRE	SS WAY.	D.	2178	+
Sta Registr	te ar	31. Data filad (Month, Day, Year)	198	s Signatura	Randa	Ц					



State of Maryland / Department of Health and Mental Hygiene

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Mow #		10a. State 10b. County		10c. City, Tow	n or Location					1	0d. fnside City Lim
1	ctor	Maryland Calve	ert	St. L	eonard	l					1 □ Yes 2€
natural, or items 23a or 28a-f show	Funeral Director	10e. Street and Number 400 Ball Road			10f.	Zip Code 2068	5		10g. Citizen o Unite	d Sta	ites
iene. r then "naturel", or frems 23a or 28a-f show fre Medical Examiner must be inclified at		11. Marital Status 1 □ Never Married 2 Married	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give			cedent of I	dispente Origin? (Sen, Mexicen, Puer Specify:	pecify Yes or No to Ricen, etc.)	Spec	ace - Americ lack, White,	
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0 m 0	Ė	19a. Informant's Name/Relationship	(Typa, Print)	19b	. Mailing Addr	ess (Street	end Number or R	ural Route Numb	er, City or Tow	m, Stete, Zip	Coda)
- N -		Vivian C. Cucu	zza- wife				27 St. I				
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Depertment of important: If i any Injury or once.		21. Signature of Funeral Service Lice	ensee	5				ausch E			
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nysician							ng, such as cardia				Approximete Intarval Between Onset and Death
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eath. Ior: After this certificate has been signed by the ettending physician end map the funeral director, page 2 should be deteched for use as the bunel-transit and page 2.	Certification: To Be Completed by Physician/Medical	Immediate Ceusa (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that imitated evants resulting in death) Lest Part II. Other afgnitIcent conditions 25. Was cese raferred to medicel examiner? 1 Yes 2 46 27. Manner of Death Naturai 5 Panding investigating 1 1 1 1 1 1 1 1 1	a. CORO b. News/ c. Al2 c. Bl d. Contributing to death bu Pofficial: Timpatter 28e. Date of Injun (Month, Day) on ba 28e. Place of Injun 28e. Place of Injun	Dua to (or as a Eptic Due to (or as a Left of the second of the secon	consequence of the Consequence o	DOA Oth 28c. Injun Wo 1 ory, office	yen in Part I. 26. Place of Dener: 4 Nursing H	23b. Did 23b. Did 24a. Was perfect 1 ath (Chack only clome 5 Resi 28d. Describe 28f. Location (City or To	tobacco use of tobacc	24b. We ever con of the state o	othe cause of deadon onset and Death othe cause of deadon onset and Death othe cause of deadon of cause death? I Poute Number, ated.
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hours efter death. Inerel Director: After this certificate hes been signed by the ettending physician end Inerel Director: After this certificate hes been signed by the ettending physician end In physician e	edical Certification: To Be Completed by Physician/Medical	Immediate Ceusa (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Lest Part II. Other afgnitIcent conditions 25. Was cese referred to medicel examiner? 1 Yes 2 No. No	a. CORO News/ b. News/ c. Al2 c. Al2 d. Contributing to death but Pofficial Tempatier 28e. Date of Injun (Month, Day) 28e. Place of Injun bad 28e. Place of Injun building, etc.	Dua to (or as a Eptic Due to (or as a Left of the second of the secon	consequence of the consequence o	DOA Oth 28c. Injun won, office ed et tha tiff on, In my co	yen in Part I. 26. Place of Dener: 4 Nursing H X? Yes 2 No	23b. Did 23b. Did 24a. Was perfect 1 ath (Chack only clome 5 Resi 28d. Describe 28f. Location (City or To	tobacco use c Yes 2 No en eutopsy med? Yes 2 No cona) dence 6 O how injury occi Street and Nun causa(s) end r date end place	24b. We every confident of furnal states of an annar as states, and due to	othe cause of dealers and Death othe cause of dealers are autopsy finding allebie prior to mplation of cause daeth? Yes 2 No
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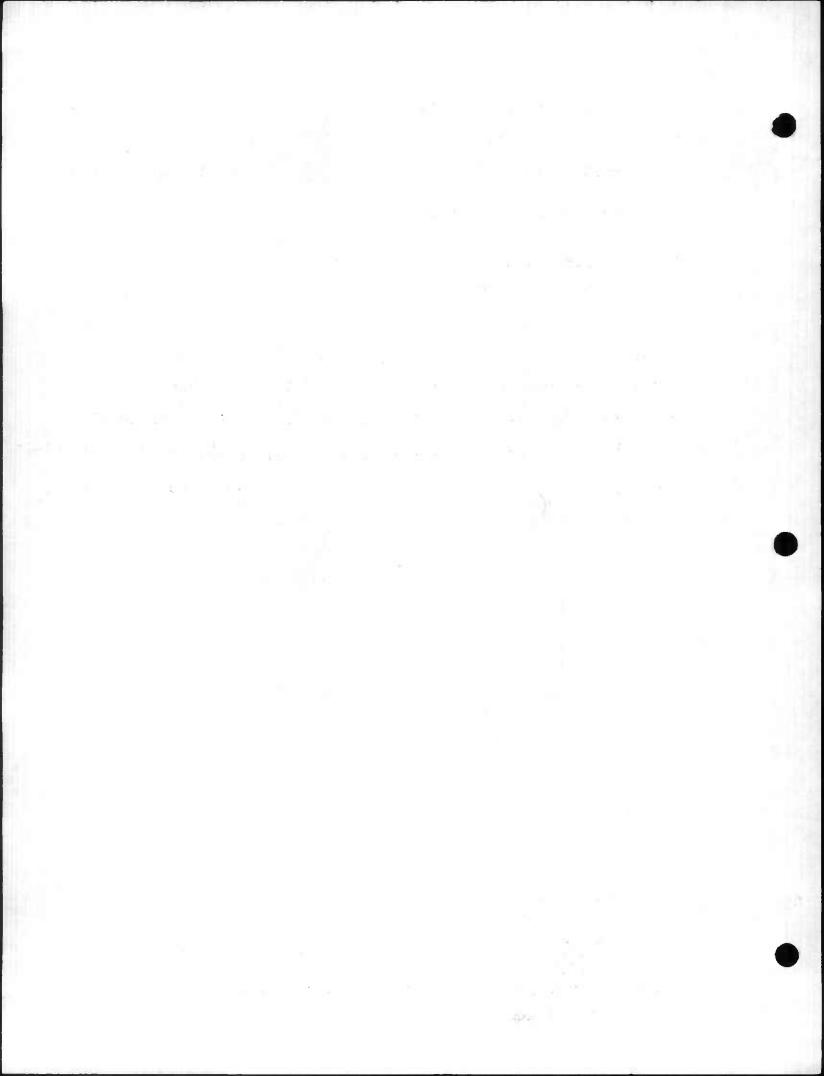
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death July 3, Day 1998 ear **Physician** Dominick Thomas Cucina, Jr. 0035AM /Medical 4a. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year Months Days if Under 24 Hrs. Houra Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth
OCT 10 1965 Mary Land **Funeral** 214 92 8995 1 JM 2 □ F 32 Yrs Director Usual Residence of Dacedant 10b. County 10c. City, Town or Location Lusby 10d. insida City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be nothed at Maryland Calvert 1 Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 11692 Cowpoke Circle Funeral 20657 United States 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 1 No if Yas, Give Yeer or Datas: Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Reca - American indian, e filed within 72 hours after d al Hygiene. I other then "natural", or Item Bieck, White, etc. 1 ☐ Never Merriad 2 ☐ Married Baltimore, Maryland 21215-0020 white 1□ Yes 2□No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) US Gov. Elementary/Secondery (0-12) College (1-4or 5+) 12 Dept. of Interior US Park Police other permit. Peges 1 and 2 should be filed.
Department of Health and Mental Hyg.
Important: If item 27 is marked other
any injury or other traumatic event, 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Dominick Thomas Cucina, Sr. Veronica Goonan 19e. Informant'a Name/Raiationship (Type, Print) 19b. Mailing Addresa (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Kaye Cucina- wife 11692 Cowpoke Circle Lusby MD 20657 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 20b. Piace of Disposition (Name of 6 T998ATexandria Virginia Serice cometery, cremetory or other place) July Metropolitan Funeral 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funarel Service Licensas 22. Neme end Addrass of Fecility Rausch Funeral Home P.A. 7 rausc 4405 Broomes Is. Rd. Port Republic MD 2067 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Batween Onsat end Death **Physician** Immediata Causa (Finai diseesa or condition rasulting in daath) /Medical Arrhytmia (Cardiac) acute Examiner Due to (or es a consaquance of) Examine b Pulmonary Hypertension years physician and the burial-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Diseasa or Injury that Initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): 88 for use as 080 signed by the a P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown Division of Vital Records, by been si 24b. Wera autopay findings available prior to complation of cause of death? Completed 24a. Wes an autopsy performed' page 2 s 1 Yas 2 No certificate 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 24 hours efter deeth. Be 25. Was case referred to medical 26. Place of Death (Check only one) examinar? Hospitel: Other: 4 Nursing Homa 5 Raaidance 6 Othar (Specify) Certification: To 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Naturel 2 Accidant 5 Panding invastigation 1 ☐ Yaa 2 ☐ No Director: / 8 Could not be datamined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital or A within 24 hours effer To the Funeral Direct completely filled in by 29e. Certifian Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature end title pl. pertilier 29c. Licansa number 29d. Data signed (Month, Day, Year) 7/3/98 D 29657 30. Nama and addrasa of person who completed causa of daath (Itam 23a) (Type, Print) Dr. Charles Judge, M.D. Prince FRederick MD. 20678 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

Jalia Davidson Rardall

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Registrar

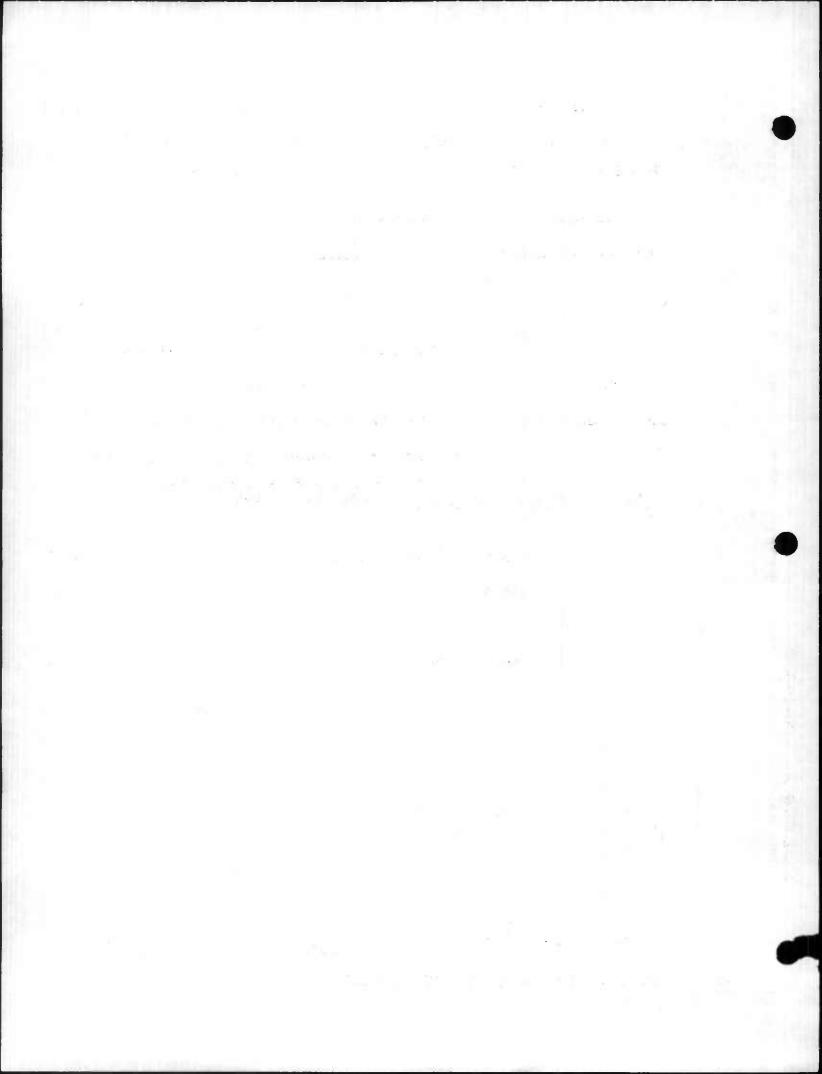


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Mabel G. Crowfis JULY 1998 17:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ALLEGENY 5. Sociei Security Number If Under 1 Year If Under 24 Hrs. Dete of Birth Month, Bay, Year 1926 Birthplace (State or Foreign Gountry) 7. Age (In yrs. last birthday) **Funeral** Sex 1□ M 2□ F Days Hours 297-22-5030 71 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be nutified at MD Allegany Cumberland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 14500 Moore's Hollow RD 21502 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1□ Yes Ž No Baltimore, Maryland 21215-0020 Specify: by Specify Widowed 4 □ Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 7: and Mental Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pemit. Pages 1 and 2 should be Department of Health and Mental Important: If Itam 27 is marked or Doc Harman Mary (Piper) 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 York Place Cumberland MD 21502 Donna R. Hare-daughter other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 0 Davis Memorial Cemetery 07 - 07Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Scarpelli Funeral Home, P.A. any ir Cumberland MD 21502 23e. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Final Acute respiratory arrest 2 months disease or condition resulting in death) **Examiner** Due to (or es e consequence of): Pneumonia 5 weeks To the Hospital or Attending Physician: The law requires that the death certificate be assecuted within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completaly filed in by the Inneat director, page 2 should be deteched for use as the bunsal-transit Examir Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): MABEL CROWFIS 297-22-5030 Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Cerebrovascular accident 5 years Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings svailable prior to Completed 24e. Wes an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes ≥ No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contiller 29d. Date signed (Month, Day, Year) 29c. License number D 23371 JULY 30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print) QAMAR ZAMAN, JOHNSON HEIGHTS MEDICAL BUILDING, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year)
JUL 0 7 1998 82. Registrar's Signature State Registrar



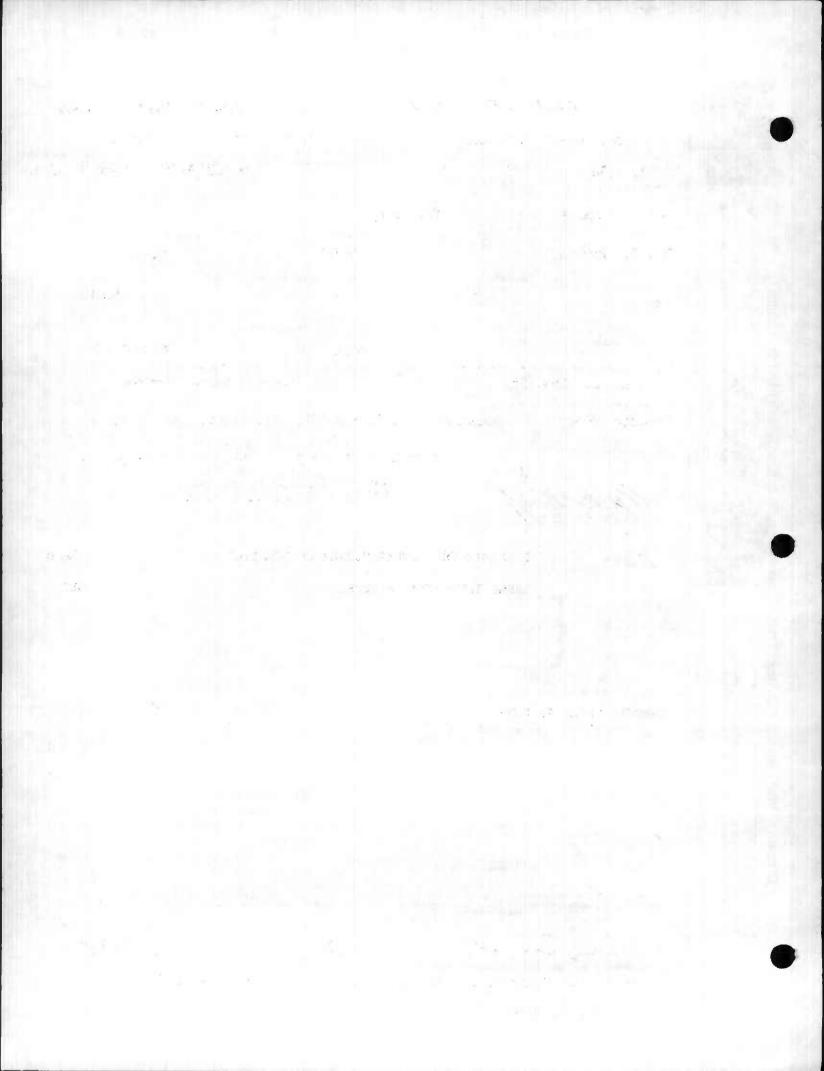
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month Day Yaar **Physician** HELEN VIRGINIA CANAN JUNE 22, 1998 0840 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Allegany Cumberland Sacred Heart Hospital Hours Min. Dec. 20, 1919 If Under 1 Year 9. Birthplace (State or Foreign Country) West Virginia 5. Sociel Security Number 7. Aga (In yrs. last birthday) **Funeral** Months 1□M 20 F Days Yrs 215-20-6458 78 Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at WV Mineral Ft. Ashby 1 ☐ Yes 2 No No Director 10g. Citizen of What Country? 10e Street and Number 10f Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Box 301 Rt. 2. 26719 U.S.A. Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, atc. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Never Married 2 Married 1 Yes 2 No Specify: White altimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Restaurant Cook 7 is marked other traumatic event, i 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Sr. Alex R. Lee Nannie Susan Hartman P 19e Informent's Name/Reletionship (Type Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) if item 27 is no or other traun Ft. Ashby, Rt. 2, Box 301, WV Beverly Henry Daughter Dete 25 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition June 1 N Burial 2 □ Crametion 3 □ Removel from Stete Department of Important: If any Injury or Green Lane Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 1998 Delray, WV 21. Signeture of Funerel Service License ²² Name and Address of Fecility Shaifer Funeral Home, Inc. 230 East Main St., Romney, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Finel a DISSEMINATED INTRAVASCULAR COAGULATION HOURS disaesa or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner DAYS LARGE INTESTINAL NECROSIS and I-transit the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or as e consequence of) physician and the burial-t Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or es a consequence of) 88 attending properties of for use as signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown CHRONIC RENAL FAILURE thet þ law requires 24b. Were autopsy tindings eveileble prior to should I 24e. Wes en autopsy Completed completion of cause of death? s certificate has t director, page 2 s The 1 ☐ Yes 2 ☐ No 1 Yes 2 No at or Attending Physician: T s after death. I Director: After this certificat of in by the funeral director, p Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of injury (Month, Dey Year) Certification: 27. Mennes of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Sulcida 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Spacify) 4 Homicide n 24 hou. the Funeral Dis-Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. Medical 29a, Certifier To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the ceuse(s) and menner steled. (Check only one) 29d. Dete signed (Month, Dev. Year) 29b. Signeture end title of certifie 29c. Licanse number m 3 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Breza M.D., you 912 Seton Drive, Cumberland, George Μ. MD 21501

DHMH 16 Rev 6/95

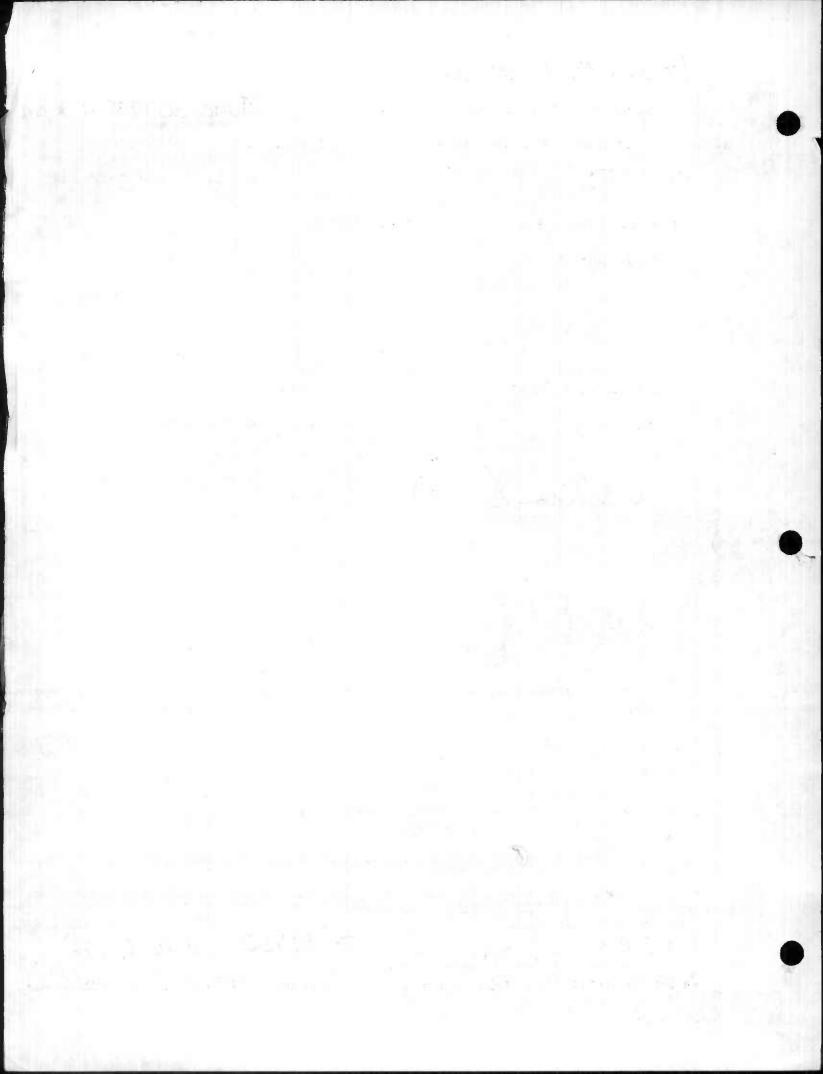
Registrar

31. Dete filed (Month, Dey, Year)

JUL 01



mended:	HA	Ha, Mus, Please Type or Print in Black Indelible Ink. Assure A State of Maryland / Department of Health and N	II Copies	Are Legi	ble.	
		Horence Miller Connad Certificate of Death		giene Reg. No.	8 2	1879.
Physic /Med		Florence Miller Conrad	June	36 /	498	3. Time of Death 11:30 pm
Exam	ner	Lions Mamor Nursing Home Cumberla	and	Alle	of Deeth egany	
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Physician /Medical Examiner	miner	23a. Part 1. Enter tha disease, or complications that cousad the deeth policy enter the mode of dying, such as cerdiac shock, or heart failure. List only one couse on each line. Immediate Causa (Final disease or condition resulting in death) Due to (or as a consequence of):	or respiretory en	rest,	tn	pproximate tervel Between neet end Deeth week
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To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funeral process.			City or Tow	n, Stete)	nner as state	d
Fo the Howithin 24 P	Medical	(Check only one) 2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurrend menner steted. 29b. Signeture end title of certifiar 29c. License number	red et tha tima, o	data and place,	and due to the	e cause(s)
4		30. Neme and eddress of person what completed ceuse of deeth (Item 23a) (Type, Print)	0	July	1,19	98
THE	te	Dr VA Ranjithan, Lions Many Nusing Home, Seton Drive 31. Date Glod Month Pay Year 2 82. Register's Signaturer	Extend	kd, Cui	nberla	nd 21502
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State of Maryland / Department of Health and Mental Hygiene \

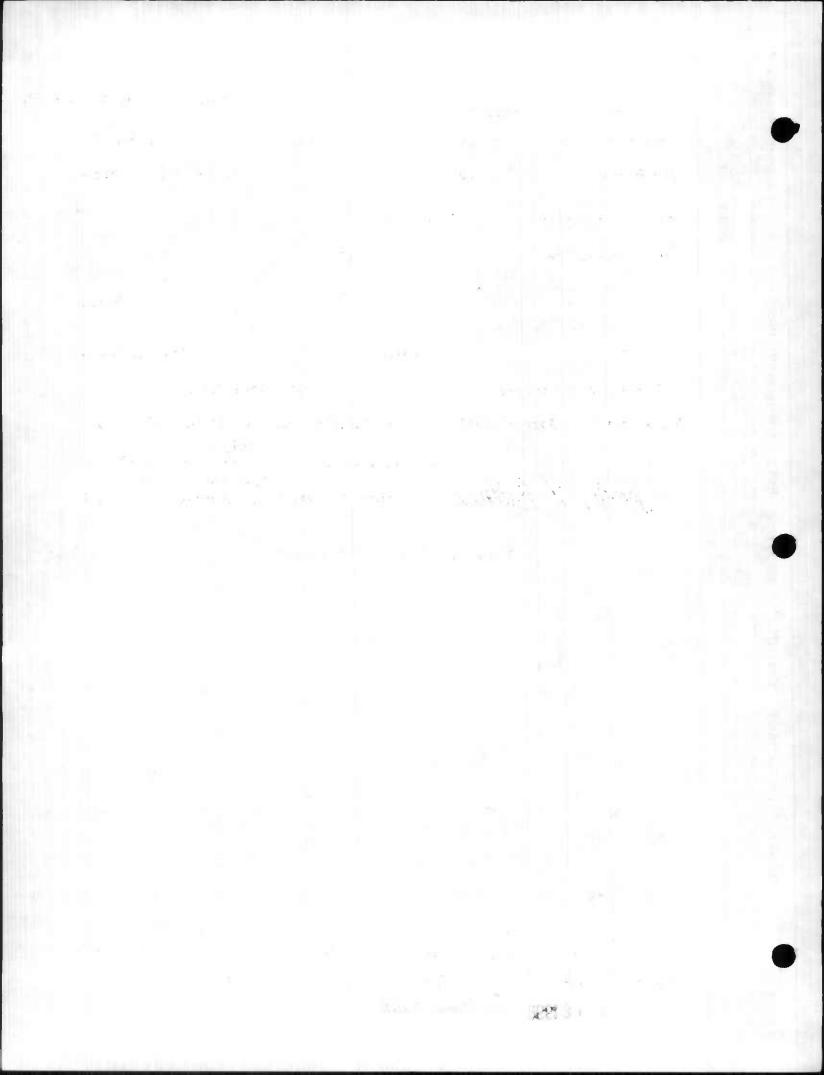
Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Month June 28. **Physician** 1998 5:40 P.M Daisy Dorsey

4a Facility Neme (If not institution, give street and number) /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Yrs. 23, 1912 **Director** 220-16-0151 86 Maryland Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglena.

Int: If Itam 27 is marked other than "natural", or items 23s or 23s-f ahow any or other transmit or hotting allow any or other transmit or notified at any or other transmit or notified at 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21701 U.S.A. Funeral 104 S. Market St. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1K Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2₺ No Specify: p 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementery/Secondary (0-12) College (1-4or 5+) Domestic Private homes 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Henry Dorsey Genevieve Fairfax 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5597 Cottonwood Ct., Dr. Robert H. Pilgram-friend Frederick, MD 21703 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 4 20c. Location - City or Town, State 1 ₺ Burlai 2 □ Cremation 3 □ Removel from State permit. Page Department of important: if any injury or 4 ☐ Donation 5 ☐ Other (Specify) 1998 Fairview Cemetery Frederick, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature & Funeral Service Licarisme 11802 Liberty Rd., Libertytown, MD 21762 23a. Pari¹. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 6 Mos disease or condition resulting in death) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequenca of): 88 980 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 200 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed s certificate has b 2000 1 Tyes 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Naturel 5 Pending after death. Director: Aft 1 Yes 2 No Investigation 2 Accident n 24 hours after des ne Funeral Director pletaly filled in by th 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital **Descripting Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner stated. 29a. Certifier edicai To the Fune completely fi (Check only one) To the To the To the 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of cartifier D09689 rilen 000 30. Name and address of person who completed cause of death (ten 23a) (Type, Print) Austin A. Pearre, 300 W. 9th St. Frederick, MD Jr. 31. Dete filed (Month, Day, Year)
JUL 0 2 1998 32 Register's Stanature State Registrar

DHMH 16 Rev 6/95



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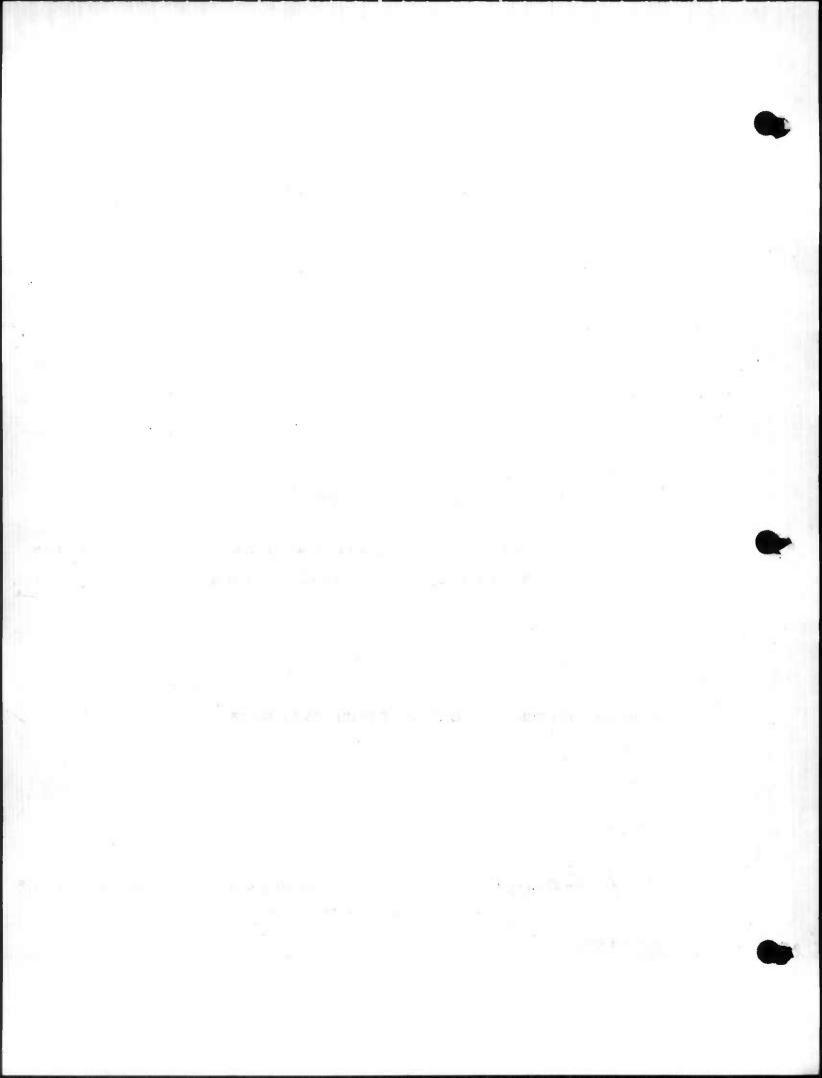
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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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COMPL	17. FATHER'S NAME (First, Middle, Last)					18. MOTNER'S NA						
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10 B	19e. INFORMANT'S NAME (Type/Print)		19b	. MAILING AD	IORESS (Street	and Number or Rural	Route Number, C	lity or Town	, Stota, Zi	(p Code)		
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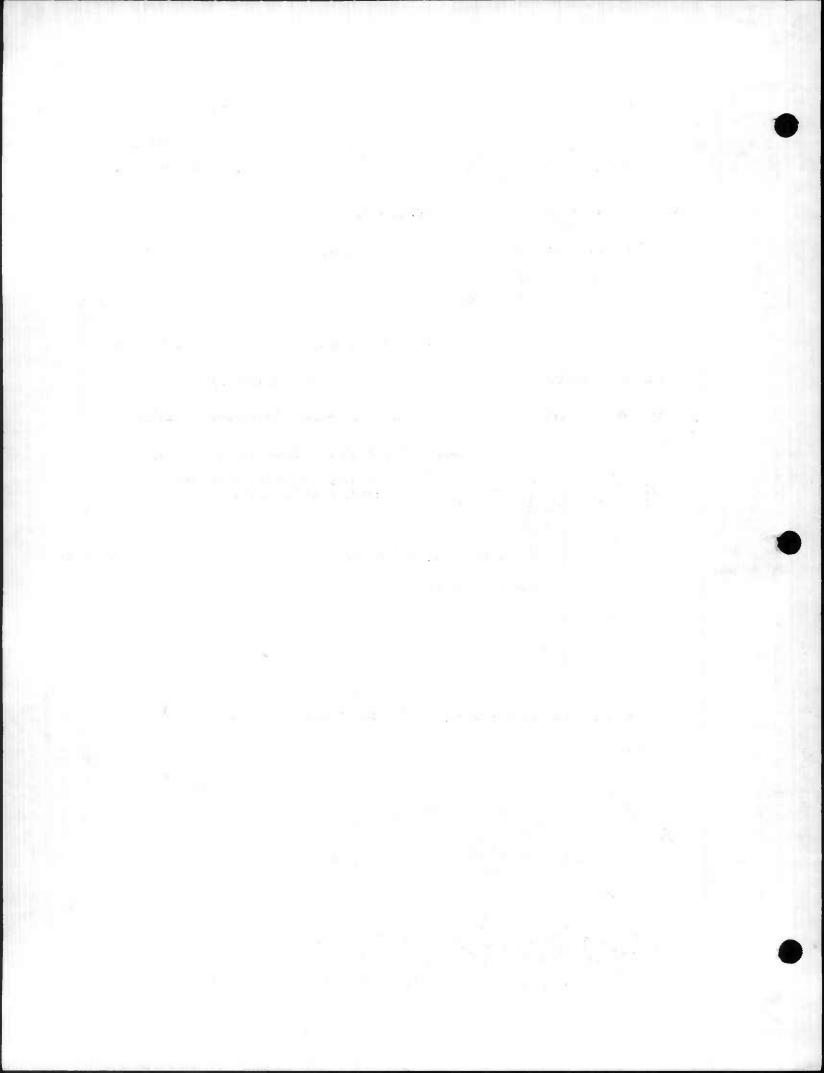


State of Maryland / Department of Health and Mental Hygiene Q

					,	Ce	rtifica	te of	Death		Reg. No.	6	100	13	
Physic		1. Decedent's Name Earl	(First, Middle, Las L. Emrick							2. Date of De Month	eath Dey	Year		of Deeth	
/Medi Examii		4a. Facility Name (If	not institution, give	e street end numbe	r)				4b. City, Town, or	July Location of Deet		of Death	2:3.	3 am	
LXGIIII	1161	Memoria	1 Hospit	1 ء					Cumber1	and		gany			
Funeral Director	Γ	5. Social Security Nu 220-10-8	mber 6. S 721 f		78 (In yrs.	last birthday) Yrs.	If Undo Months	er 1 Year Days	If Under 24 Hrs Hours Min.	8 Date of Bir			lece (Stete try)	or Foreig	
P.		Usual Residence of						1							
a-f ahow	ctor	MD MD	Allegany	7	10c. Ci	cumber		l				10	Od. Inside (City Limit	
th with the	Funeral Director	10e. Street end Num 11523 Ba	nk Avenu	e				ip Code 21502	2		10g. Citizen of US.		it Country?		
iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mentel Hygiene. If Itam 27 is merked other than "natural", or frems 23a or 28a-f show or other traumetic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Marrie 3 □ Widowed	_	12. Was Deceden At ned Forces 1 Yes 2 If Yes, Give Year or Dates	t Ever in U ? No WWII	,S. 13.	Was Dec If Yes, sp 1□ Yes	X	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	14. Rac Ble Specif	ce - America ck, White, o			
72 ho	ted		15. Decedent's Ed fy only highest gre			16e. Dece	dent's Us	uel Occup	al Occupation rk done during most of working se retired)			usiness/Ind	ustry		
i within jiene. r than "r	Completed	Elementary/Secon		College (1-4or	5+)	Retire	d Er	ise retired	er	Kuig	B&O Ra	ilroa	ıd		
2 should be filed within 72 hours end Mentel Hygiene. Is marked other than "natural", aumatic event, the Medical Exa	To Be C	17. Father's Name (I	First, Middle, Last) E. Emric	k			_		18. Mother's Nar Maude		, Meiden Sumer	ne)			
and 2 shousaith end Natural	-	19a. Informent's Ne Verna Em	me/Relationship ()						end Number or Au enue Cum	ural Route Numb berland	MD 2150	Stete, Zip	Code)		
Pe ne ne ne ne ne ne ne ne ne ne ne ne ne				Removel from State	20b. Res	Plece of Disposametery, cres Stlawn	osition (No matory or Memo	ome of other place rial	Gardens	Dete 07/06	20c. Location		wn, Stete		
permit. Pe Depertmen Important: any Injury once.		21. Signeture of Fur	erel Service Lican	See JAM	Næ	W- 22	Sca Cuml	rpeii perla	iofFullera and MD 25	l Hame, 102	P.A.				
.Physician		23a. Pert1. Enter the shock, or hear	e disease, or comp failure. List only	lications that cause one cause on eech	ed the deat	h. Do not en	ter the mo	de of dyin	g, such as cardled	or respiretory e	orrest,		Approxima Intervel Be Onset and	etween	
/Medical Examiner	П	Immediate Cause (F disease or condition resulting In death)		_{e.} Ventric		fibril						m	inute	S	
70 44	ne			Coronar								V	ears		
icete be executed physician and s the buriel-transit	I Examiner	Sequentially list con if any, leeding to Imr cause. Enter Under Ceuse (Disease or in	ditions, mediate lying	0.		or as e consec	annual .								
death certificete be executed e attending phystcian and of for use es the buriel-transit	in/Medical	that Initiated events resulting In deeth) L		d	Due to (o	r es e consec	juence of)	:							
deat	sicia	Part II. Other signific	ant conditions co	entributing to death	but not res	ulting In the u	nderlying	cause giv	en in Part I.	23b. Dld	tobacco uae co	ntribute to	the cause	of death	
requires that the de- een signed by the a hould be detached f	by Physician/			t failure						10	Yes 20 No		ably 4		
	Completed	1 July	1998							24a. Wes	an eutopsy ormed?	con	re autopsy sileble prior apletion of deeth?	rto	
	Ö									1 🗆	Yes 2 No	1	Yas 2	□No	
Physician: The law ruthis certificate has b rral director, page 2 s	Be	25. Was case referre	-	Hospital:				Oth Oth	26. Plece of Dec						
Phy this	To To	1 Yes 2 N N 27. Magner of Deeth	10	1 2 Inpat 28e. Date of In		ER/Outpatier 28b. Time o	-	UA	4 Li Nuising r		dence 6 Oth)		
Attending in death.	cation	1 Naturai 2 Accident	5 Pending Investigation	(Month, D	ay Year)	Injury	М	28c. Injun Worl	k? Yes 2□No	200. Describe	now injury occur	160			
245	Certification:	3 ☐ Sulcide 4 ☐ Homicide	6 ☐ Could not be determined	286. Place of If	njury - At h tc. (Specif	ome, farm, str y)	eet, facto	ry, office		28f. Location (City or To	Street and Numl wn, Stete)	per or Rurai	Route Nu	mber,	
To the Hospital of within 24 hours extended To the Funeral Completely filled	edicai	29a. Certifier (Check only one)	Certifying Phy	valcian: To the best liner: On the basis end manner	examina experies	wledge, death tion end/or in	occurred vestigatio	d et the tin	ne, date and pleca pinion, death occu	, and due to the rred at the time,	ceuse(s) and made end plece,	anner es st and due to	eted. the cause	(s)	
Within To th	M	29b. Signature and t	11/1/80	1. At 11		181	A	c. License			29d. Date signe				
5 M/		30. Name and addre		UIJUS ombieted cause of					4393		July		1998		
Ylos		Dr. Fred					ts M	edica	1 Bldg.,	Cumber	land, MI	215	502		
Sta	ate	31. Date filed (Month	n, Day, Year)	32. Regist	trar's Signe	ture									

220-10-8721

EARL EMRICK



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an		W	avne	Edw	ard	Fox			Month	Day	Yaar	4:00PM
cal ner	4a. Facility Nama (1 0/1		4b. City, Town, or		29, 1998 4c. Coun	ty of Deatl	Table of America
ici	7500 0-4	than Dand						0.1				
	7502 Gait 5. Social Security N		6. Sax	7. A	ga (In yrs. la	st birthday)	If Undar 1 Yaa	Sykesville ir If Undar 24 Hrs	8. Data of Bir	th	Carr	
		2 - 6145		2□ F	.ga () / 0. 10		Months Days		. (Month, De	y, Year)	Co	hplaca (Stata or For untry) Maine
	Usual Residence of				4	8			May 6, 19	330		Mairie
	10a. Stata	10b. County			10c. City,	Town or Local	tion					10d. Inside City Li
ŏ	MD		0	arrall		Cyl	cesville					1□Yes 2K
Director	MD 10e. Street and Nu	ımber	C	arroll		Syr	10f. Zip Coda		1	10g. Citizen o	f What Co	unto/?
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in in	11. Marital Status	ata da a Milliana		Armed Forces	?	lf Y	es, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	to Rican, atc.)		ack, White	rican Indian, a, atc.
by F	1 Never Marr			1 X Yas 2 □ If Yes, Give		1	Yas 2 No	o Spacify:		Spec	ify:	
	3 Widowed			Yaar or Datas:	9/21						N	/hite
ete	(Spec	 Decedant city only highes 				(Giva kir	it's Usuel Occu id of work doni	a during most of wo	orking	16b. Kind of	Business/	Industry
d H	Elementary/Seco	ondary (0-12)		College (1-4or	5+)	Iffa. DO	NOT use ratin	red)				
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Be	17. Fathar's Nama	(First, Middle,	Last)					18. Mothar's Na	me (First, Middle	, Maidan Sume	ama)	
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	Pá	atricia M.	Fo	ox /wif	e		7502 G	Saither Road	Sykesville, I	MD 21784	ļ.	
	20a. Mathod of Dis	position			- 00	nea of Dispositi	on (Name of	(ace)	Date	20c. Location	- City or	Town, State
		☐ Cramation 5 ☐ Other (S)		oval from State	3		NOTE OF STREET		1	Marr	iottsville	Maryland
	21. Signature of Fu				C	rest Lawn			7/3/98			, ivialylatia
	1.00	13				22.1	and Addi	ress of Fecility Jeffrey N. Zu	mbrun Fune	eral Home	&	
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				-				6028 Sykesv	ille Road Ele	lershura M	Aandan	d 21784
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	17	(Final			ed the death.	ry Fa.	lore	6028 Sykesv ying, such as cardia	ille Road Eld ic or raspiratory a	dersburg, A	1	Onset and Deat
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Registrar

State

31. Date filed (Month, Day, Year)

JUL 0 1 1998

32 Ragistrar's Signature

Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or items 23 a or 28=1 show any injury or other traumatic event, the Medical Examination must be halfind at angles.

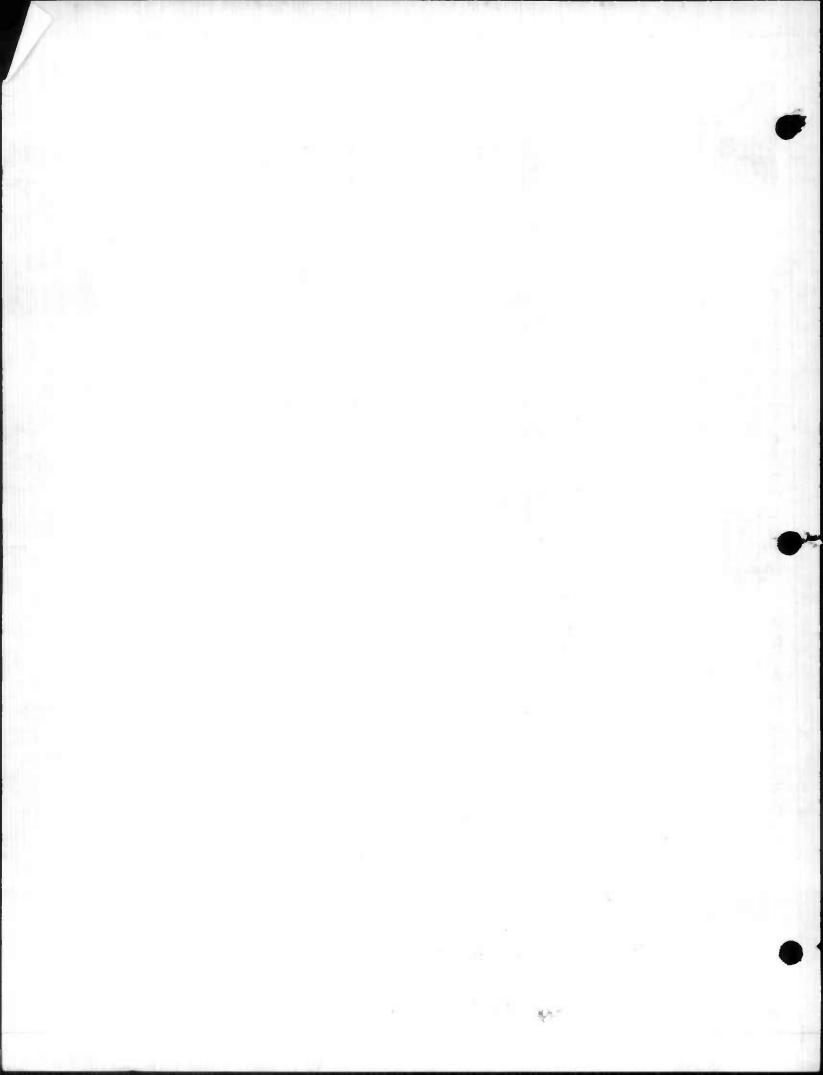
Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

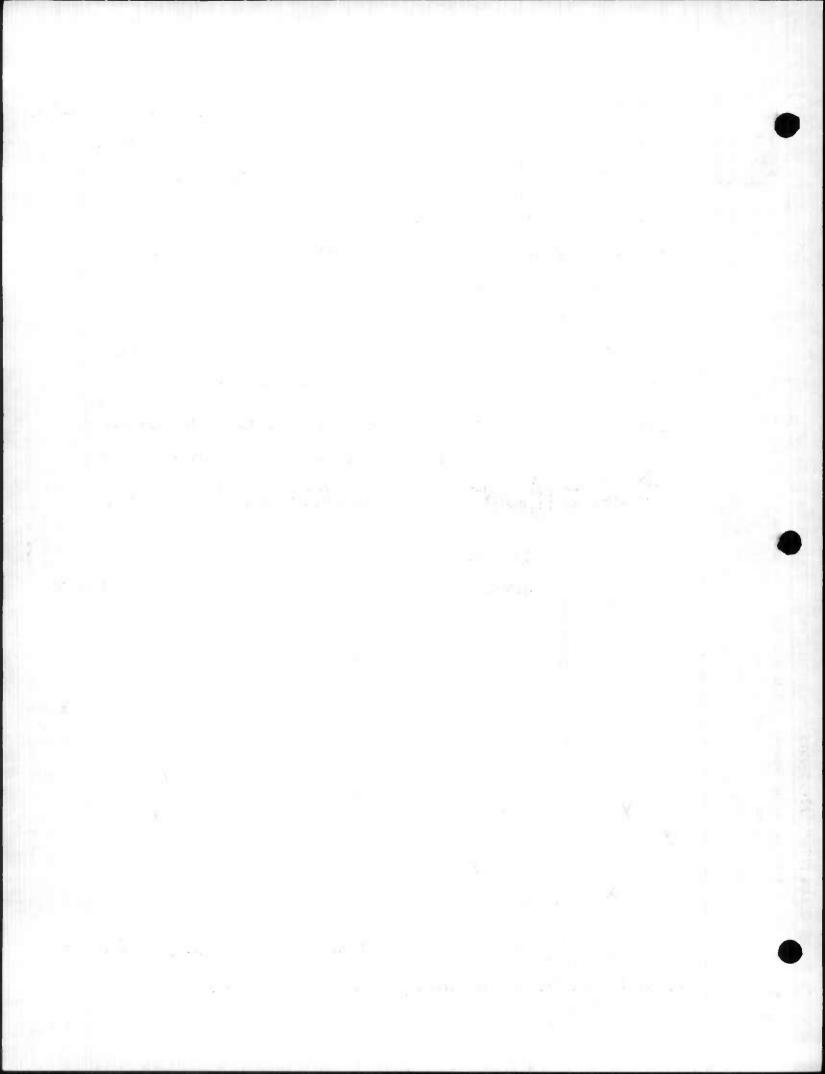
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



					C	ertifica	ate of	Death		Reg. No.	8 2	1885		
Physician		1. Decedent's Name (First, Middla, La							2. Data of De Month	eath Day	Yaar	3. Time of Death		
/Medical	-	GLEN DONALD I	OLK						- 0	5. 1998		10:30A.M.		
Examiner	r	4e. Fecility Name (If not institution, gi	ve street and number	er)				4b. City, Town, or	Location of Dae		nty of Death			
		MEMORIAL HOSPIT				M Hand	4 Va	CUMBERL			LLEGAN			
Funeral Director			Sax 7 11☑M 2□F	Aga (In yrs. 84	last birlhdi Yrs	Month	ar 1 Yaa s Deys			rth a <i>y, Yaar)</i>	9. Birthp	placa (Stata or Foraign htry)		
	1	Usual Rasidanca of Decedant							OCT 31	1913		PA.		
Mou III		10e. Sfata 10b. County		10c. Cit	y, Town or	Location	_				1	Od. Insida City Limits		
to rot	0	MARYLAND ALLEC	SANY	CU	MBERI	LAND						1 ☐ Yas 2(XNo		
83a or 28a-fa at be notified at Director	a Dire	10e. Street and Number 12801 MASON ROAL	N.E.			10f. Z	2150)2		10g. Citizan d		at Country?		
Department of Hauth and Mental Hyglena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any fijury or other traumetic event, the Modical Examiner must be notified at once. To Be Completed by Funeral Director	2	11. Marital Status 1 □ Navar Married 2 ☒ Marriad 3 □ Widowad 4 □ Divorced	12. Was Deceda Armed Forca 1 Yas 2 If Yas, Giva Yaar or Data:	s? XNo	S. 1			Hispanic Origin? (9 ban, Maxicen, Puer Spacify:	Spacify Yes or Noto Rican, atc.)		4. Raca - American Indian, Bleck, Whita, atc. Specify: WHITE			
natu	200	15. Decedant's E (Spacify only highast gr	ducetion ada complated)		16a. De	cedant's Us	ual Occu	pation a during most of wo	orkina	16b. Kind of	Businass/In	dustry		
ygiena. ner than "natura nt, tra wedgall Completed		Elemantary/Secondary (0-12)	Collega (1-4c	or 5+)										
Co LE	3	12	1		MARY	LAND	STAT	E POLICE	POLI	CE				
ed oth		17. Father's Nama (First, Middla, Last SIMON FOLK	/						me <i>(First, Middle</i> AH LIVEN		urne)			
metic	-	19a. Informant's Name/Ralationship	Tune Print		10h 14	ailine Adde-	00 /04				m Char Ti	Corto		
trau				TRE				ot and Number or R						
othe	1	MILDRED K. FOLK 20a. Mathod of Disposition	W	IFE 20b. P	lace of Dis	sposition (N	ama of	OAD N.E.	Data	20c. Location				
fury or	-	1 N Burlal 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Special	(y)	(a	-	EMETE	RY	JULY 8,	1998	CUMBERI	AND M	ARYLAND		
any in		21. Signature of Funaral Sarvice Lice	Merut	レ		MERRI'	TT-A	ass of Facility DAMS FUNE UR STREET			RYLAN	D		
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		radding in datally		Due to (o	ras a con	sequenca of	f):				1			
nsit nin			b. Anemia								-	6 months		
burial-transit		Sequentielly list conditions, if eny, leading to immediata ceusa. Enter Underlying Cause (Diseasa or injury that initiated avents		Dua to (o	r as a con:	sequance of	f):				i			
2 2		Cause (Diseasa or injury that initiated avents	C	Due to los		sequance of	١.							
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etached for us	3										-			
detached	2	Part fl. Other significant conditions of	ontributing to death	but not resu	ulting In the	a undarlying	causa g	ivan In Part f.				the cause of death?		
be detact									10	Yes 2□ No	3 ☐ Prol	bably 4 Unknown		
should should									an autopsy ormed?	opsy 24b. Wara autopsy find available prior to complation of cau of death?				
page 2									10	Yas 2 No	1[]Yas 2□No		
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unara unara unara		27. Manner of Daath 1 Natural 5 Panding 2 Accidant investigatio	28a. Data of Ir (Month, L	jury Day Year)	28b. Time Injur		28c. Inju Wo	nyat ork?]Yas 2 □ No	28d. Dascribe how injury occurred					
al Director: Affart led in by tha funara Certification:		3 ☐ Suicida 6 ☐ Could not be datarmined	286. Place of	euc. (Spacify	ma, farm,	straat, facto	ory, office		28f. Location (City or To	Street and Nur wn, Stata)	nber or Rura	I Routa Number,		
To the Funeral Director: A completely filled in by that Medical Certificati		29a. Cartifiar (Check only one) 2 Modical Exer	ysician: To the bes niner: On the basis and magnar	of examinat	wledge, de ion and/or	ath occurred investigation	d at tha t en, in my	ima, date and place opinion, death occi	a, and due to the urred at the tima,	cause(s) and i date and place	nannar as si a, and due to	tated. tha causa(s)		
To the comp		29b. Signature end titla of pertific	//			2	9c. Lican	sa number		29d. Data aigr	ad (Month,	Day, Year)		
7		11-6	12			D	367	66		July	6	1998		
,		30. Name and addrass of person who	completed cause of	daath (Itam	23a) (Typ	oe, Print)								
	1	Dr. Vik Poonai, 9	20 Nation	al Hi	ahum	C	umho	rland, MI	2150	2				
State	ľ	31. Date filed (Month, Day, Year)	20 Nation 32. Regis	strar's Signa	lure	,		Journey MI	2100					
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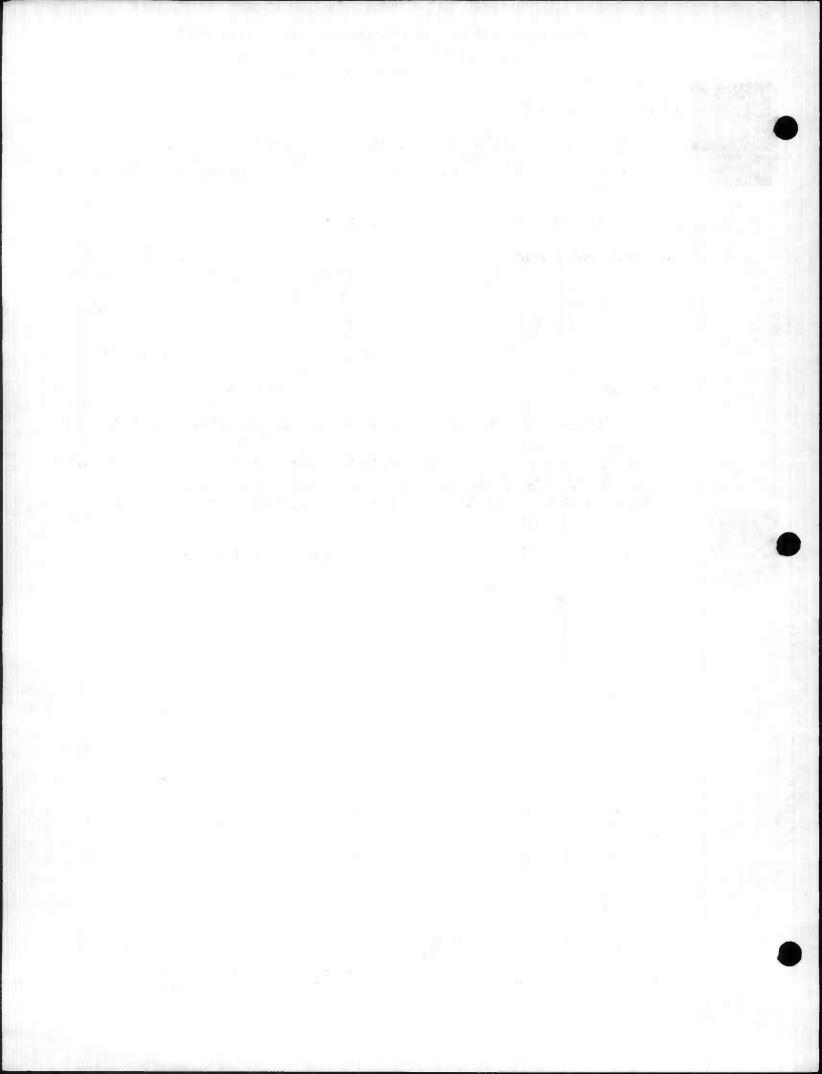
GLENN FOLK 217-03-4526



State of Maryland / Department of Health and Mental Hygiene

Marie Goldsmith Division of Vital Records. P.O. Box 68760

				Ce	rtificate of	Death		Reg. No.	20	41000		
		1. Decedent'a Name (First, Middle, Las	st)				2. Date of Month	Death	Vees	3. Time of Death		
	rsicia: ledica	MAKIE GULDS	HTIM				Ju1	3 Day	Year 998	8:15 am		
	mine	A = T = 100 + h l = - + 100 = - + 2 = + 10 + + 1 = - + 10 + 10 = - + 10 + 10 = - + 10 + 10 = - + 10 + 10 = - + 10 + 10 = - + 10 =	e street and number)			4b. City, Tov	vn, or Location of D		County of Death	1		
		3666 Pine Cone				Wald			narles			
Fune Direc		5. Social Security Number 6. S 078-09-5603 Usual Residence of Decedant	ex 7. Age (In yrs. Ia	yrs.	If Under 1 Year Months Days		Min. (Month,	Birth Day, Year) RY 21,	Cou	untry)		
and tand		10a. State 10b. County	10c. City,	Town or Lo	ocation					10d. Inside City Limits		
If I S 15-00 C U C I I I I I I I I I I I I I I I I I		MARYLAND CHARLES 10e. Street end Number			WALDOR	F		10- Chi-	and Miller Co.	1 ☐ Yes 2 X No		
h with			RCLE		· ·	0602		UNITED STATES				
deat	N. I	3666 PINE CONE CI 11. Maritai Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of	Hispanic Orig	In? (Specify Yes or Puerto Rican, etc.)	No- 14				
within 72 hours after jiena. r than "netural", or lit	- Very service	3 ☐ Widowed 4 X Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No		Puerio Ricari, etc.,		Specify:			
d within 72 hours af Jiena. r than "netural", or		15. Decedent's Ed (Specify only highest gra-	lucation de completed)	16a. Dece	dent's Usuai Occu	ipation during most	of working	16b. Klnd	b. Kind of Businass/Industry			
within then		Elamentary/Secondary (0-12)	Collega (1-4or 5+)	lifa. DO NOT use retu					9. Birthplace (State or Foreign 1919 NEW YORK 10d. Inside City Limits 1 Yes 27 No en of What Country? TED STATES 6. Raca - American Indien, Black, White, etc. 6: Specify: WHITE 6 of Businass/Industry			
Hied the	Mental Mental arked o	12 17. Fathar's Name (First, Middle, Last)	U	WA	LTRESS	18. Mother	's Name (First, Mid			ITS		
D la D							RENE STAG		omano,			
2 should and Mis mark		19a. Informant's Name/Raiationship (7	Type, Print)	19b. Mailie	ng Address (Stree				Town, State, Z	ip Code)		
C T N L		PATRICIA SCHERMER	HORN- DAUGHTER	366	6 PINE C	ONE CI	RCLE, WAL	DORF,	MARYLAN	D 20602		
mit. Pages 1 and partment of Haalt portant: If item 27	3	20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of matory or other pla		Data					
		1 ☐ Burial XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovei from State		EMATORY,	•	4. 1998	WALD	ORF. MA	ARYLAND		
permit. Pag Department Important: I	9	21. Signature of Fundal Service Licer	so Latera	22	2. Name and Addr	ess of Fecility	1		,			
a a a E a	8	MGB MARK G. BROHAW	N M00053				L HOME, I		20604			
_		23a. Part1. Enter the disaase, or comp shock, or heart failura. List only		Do not ent	er the mode of dy	ring, such as	DORF, MAR cardiac or respirator	y arrest,	20004	Approximete		
Physici	an	SHOOK, OF HORITIANDIA. LIST OFFIY	one causa on agon ma.						1			
/Media		immediate Causa (Final disease or condition	SQUAM	201	CE	2	CAMO	ER		10428		
Examir		rasulting in death)		as a consec					I	103		
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ertificate be executed ling physician and lase the build-transit			Due to (or	as a consec	quence of):							
ificata be e	Follow	Cause (Disease or Injury that Initiated events resulting In death) Lesf	Due to (or a	as a conseq	uenca of):				i			
Centi	SAL SAL		d									
death c e attended for us		Part II. Other significant conditions co	antributing to death but not regul	ting to the u	nderlylna osuce o	iven in Part I	296 [lid tobacco u	ee contribute	to the cause of death?		
t the	Chicleria		with butting to death but not leading	ung in the a	riderlying dauge g	ivon art ait i.		□ Yes 2X		obably 4 Unknow		
at se the gned	3											
law requires that the death certific as been signed by the attending processing to should be detached for use as	patalomo						24a. V	/as an autops erformed?	8	Were autopsy findings syallable prior to completion of cause of death?		
a he	2						1	□Yes 2∭1		□Yas 2□No		
icien: T	2		_			26. Place	of Death (Check or					
Physicien: rthis certific		1 Yes 2 → To	Hospital: 1 ☐ Inpatiant 2 ☐ E	R/Outpatier	nt 3 DOA				☐Othar (Spec	oify)		
ding Phys			(Month, Day Year)	28b. Time of Injury	28c. inju	ury at ork? ☐ Yes 2 ☐ N	28d. Descri	me 5 Raaidance 8 □ Othar (Specify) 28d. Describe how injury occurred				
To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th		3 Suicide 6 Could not be determined		ne, farm, str	eet, factory, office		28f. Locatio City or	n (Street and Town, State)	Number or Ru	ral Poute Number,		
the Hospital of this 24 hours a the Funeral D	Odlosi		valctan: To the best of my know	iedga, death	n occurred at the t	ima, data and opinion, daat	I place, and due to	ha cause(s) a na, data and p	and mannar as place, and due	statad. to the cause(s)		
To the P Within 2 To the P	2		and mannar stated.			se number						
5 ¥ 5 8	3	Alo 0	M MM					250. Date	signed (Month	95		
		arigh-	1140	V//		8352) , [()		
		30. Nama and addrass of person who o			Calli	bridge	e Prof (tr St	e 102	1 1 0060		
	Ctot	Krishan Mathur 31. Date flied (Month, Day, Year)	32 Registrar's Slonetu	Ire .		ngton	ku.,Wal	.dort,	Mary	land 2060		
Reg	State istrar		98 Ju Davel	wor Par	LK							



State of Maryland / Department of Health and Mental Hygiene

_						Certific		Death		Reg. No.	8 ,	21887		
п	Physic	ian	Decedent's Name (First, Middle, La						2. Date of De Month	ath Day	Year	3. Tima of Death		
ı	/Medi			YLVESTER	GRAY	Y	SR		JULY 1	170-		16:29pm		
1	Examii	ner	4a. Facility Name (If not institution, given Calvert Memorial					4b. City, Town, or I Prince Fr			of Death	rt		
	Funeral Director		5. Social Security Number 6. 5		(In yrs. last birt	Yrs. H U	nder 1 Year this Days		8. Date of Bir (Month, Da Oct. 2	th Year 1902	9. Births Cour Mar	place (State or Foreign yland		
	land		10a. State 10b. County		10c. City, Town	or Location					1	10d. Inside City Limits		
	h the Maryland r 28a-f show	ctor	Maryland Calve	rt	Sur	nder1a	nd					t ☐ Yes 2 No		
	th with the 23a or 28	al Director	10e. Street and Number 6822 Persimmon	Lane		101	f. Zip Code 2068	9		10g. Citizen of V		ntry?		
21215-0020	72 hours effer death with the Maryland "natural", or frems 23a or 28a-f show ideal Examiner must be notified at	by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yas 24 N If Yes, Give Year or Datas:				Hispanic Origin? (S ean, Mexican, Puerl Specify:	pecify Yes or No o Rican, atc.)		e - Americ ck, Whita, Bla			
5-0	other than vent, the Mer		15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's (Give kind o	f work done	during most of wor	kina	16b. Kind of Bu	usiness/in	dustry		
121			Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT use		od)		Farm	dna			
			17. Fathar's Name (First, Middle, Last)		га	imer	18. Mother's Nan	ne (First, Middle					
Maryland	D S D S	To Be	James	Gra	a V			Mary	, , , , , , , , ,	Jone				
ary	2 should end Men is marke	-	19a. Informant's Name/Relationship (-	Mailing Add	iress (Stree	t and Number or Ru	ral Route Numb	er, City or Town,	State, Zip	Code)		
	1 end 2 Health e		Alberta Jones/Da	ughter	396	55 Hun	ting	Creek Roa	d Hunt	ingtown,	MD	20639		
Baltimore,	9 5 = 0		20a. Method of Disposition 1 X Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specif		20b. Plece of cometen				Date /6/98	20c. Location - Sunder1				
Balt	permit. Pege Department of Important: If any Injury or once.		21. Signeture of Funeral Service Licer	- 40	,			Beach Rd		neral Ho		, MD20678		
			23a. Part1. Enter tha disease, or com shock, or heart failure. List only		the death. Do n	1					T	Approximata interval Between		
	Physician /Medical		Immediate Cause (Final disease or condition					noma/	I			Onset and Death 2 News,		
	Examiner	iner	resulting in death)	Malio	Due to (or as a c	onsequence Ple	of):	1 Effu	erors			4-6 whs.		
50,	tificate be executed g physician and es the buriel-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Proa	de to (or as a c	onsequence	Zen	1 Effu	allur	2		4-6 west		
Box 68760,		n/Medica	that initiated events resulting in death) Last	- 7	ue to (or as e co									
œ	death e ette ed for	sicia	Part II. Other aignificant conditions of	ontributing to death but	t not rasulting in	the underlyi	ino causa di	ven in Part I.	23b. Did	tobacco use cor	ntributa to	the cause of death?		
s, P.O.	es that the death cer igned by the ettendir be deteched for use	by Physician/M	Anemia									bably 4 Unknown		
Records	aw requires been so 2 should	Completed b	Arteroscherot Cerebrovasch	e Cardro	wescul	ar I	HYCA	J6.		an autopsy rmed?	av co	ere eutopsy findings allable prior to mpietion of cause death?		
	The late he	MO(Aortre Stenus	13/Jclero	417				10	Yes 2 No	1[Yes 2□ No		
Vital	iclan: The lev certificate hes rector, page 2	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	one)				
of	Physician: this certific ral director,	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatien		-/-	DUA		ome 5□ Resi	dence 6 Oth	er (Specif	y)		
on	ding P. After funer	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day		ime of jury M	28c. Inju Wo	ryat rk? Yes 2 □ No	28d. Describe	how injury occurr	ber			
Division	or Atten efter deel Director:	Certification:	3 Sulcide 6 Could not b determined			m, street, fa			28f. Location (City or To	Street and Numb vn, State)	er or Rura	al Route Number,		
	To the Mospital or Attending Physician: The is within 24 hours efter deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai C	29a. Certifiar (Check only one) 1 Certifying Ph	ysician: To the best of hiner: On the basis of a and menner state	examination and	death occur Vor investiga	rred at the ti	me, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and ma date and place, a	nner as s and due to	tated. o the cause(s)		
	To the To the comp	Me	29b. Signature and title of certifier	temas	MD		29c. Licen	217 246		29d. Date signed				
	2		30. Name and address of person who			Type, Print)		, ,						
	3		Dr. Gerald Ste	rner,M.D.,	Prince	Frede	erick,	Maryland	20678		_			
	Sta Registr		31. Dete filed (Month, Day, Year)	32. Registrar	's Signature			_						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eva I. Gross June 27,1998 12,30 A.M /Medical 4a. Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westernport, Md Allegany Moran Manor Nursing Home
5. Social Sacurity Number 6. Sex 7. Age (Ir if Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 30,1900 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) 236 36 2024 1 M 2 TF 98 Yrs. Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits Director 1 ☐ Yes 2 ☐ No Mineral Piedmont 10e, Sfreef and Number 10f. Zip Coda 10g. Citizen of What Country? Funeral 51 jones Street 26750 U.S.A. 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armad Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White py Specify: 3 Widowed 4 □ Divorcad White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Self 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Isaac Lee Adams Rachael M. Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) Baden Pa 15005 Betty Grant 143 Anothy Wayne Terrace 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 6/29/98 Philos Cemetery 0/29/90 Westernport, 110
22. Name and Address of Facility
Fredlock Funeral Home P.O.Box 4 Piedmont, Wv Westernport, Md 21. Signature of uneral Ser 23a. Parti. Enter the disease, or complications that caused in shock, or heart failura. List only one cause on each lina. death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximate Interval Batween Onset and Death Cardio - Pulm. Immediate Ceuse (Final disease or condition resulting in death) Congestive Examiner Dua to or as a consequence of): Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Athero solevotia Due to (or as a consequence of): Valerelan dicesse Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? 1 ☐ Yss 2 No 3 ☐ Probably 4 ☐ Unknown delimentia 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examinar? Hospifel: 1 ☐ Inpatient 2 5 ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Examiner sician and burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attanding physician for use as the burie ata has been signed by the a page 2 should be datached t cartificata or Attending Physician: director. this funeral Aftar s aftar death.

I Director: Aft
of in by the fur

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

the Maryland

filed withIn 72 hours aftar

Hygiana.

permit. Pagas 1 and 2 should be filed I Department of Haalth and Mantal Hygis Important: If Item 27 is marked other?

other

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Physiclan

/Medical

Baltimore, Maryland 21215-0020

Physician/Medical þ Be Completed Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 Matural 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be determined 28a. Place of Injury - At home, farm, sfreat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 D-Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) end manner as steted. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and fitle of certifiar 29c. Licanse number 29d. Date signed (Month, Day, Year)

M.D.

P. On BOX 696.

(Ithm 23h) (Type, Print)

State Registrar

filled in by

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24 hours a Hospital

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> Mahesh 31. Date filed (Month, Day, Year)

30. Name and address of person who completed

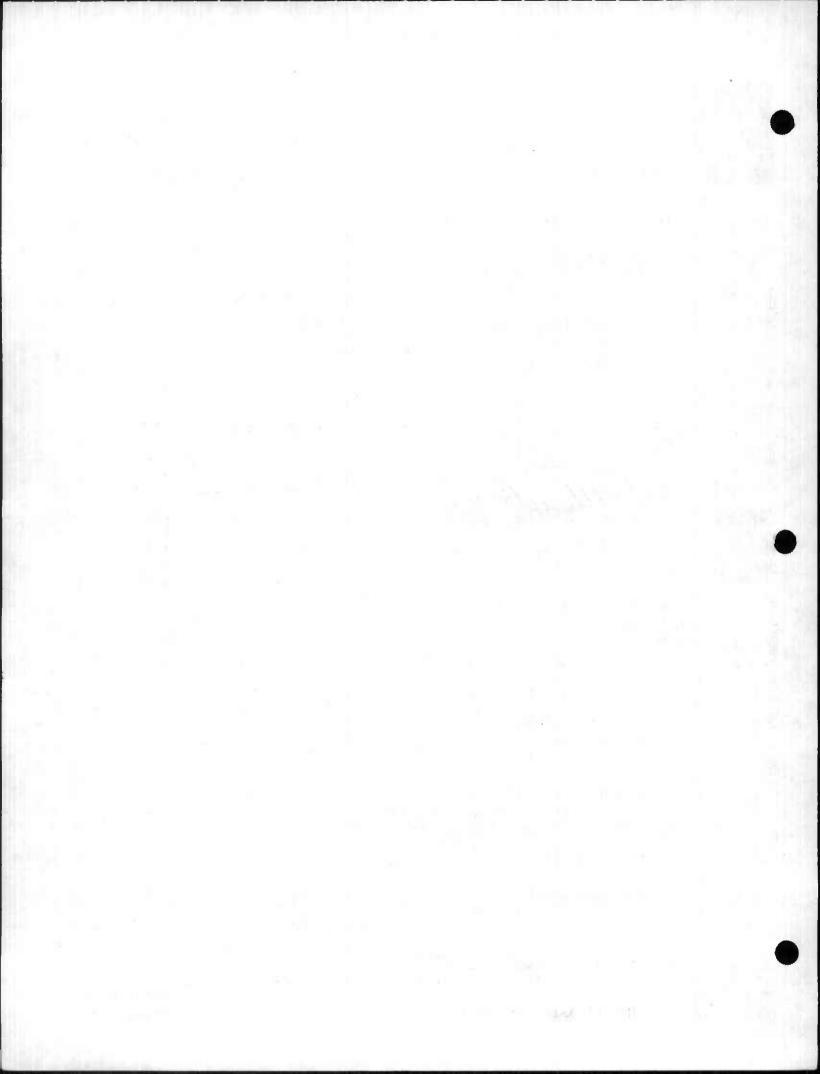
32. Registrar's Signature

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Shropp



JOHN HILTON 98-3507-039 B.K.S

ITEMS: #23 PART I, 27 PER MEO FILM G761 7-17-98 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death

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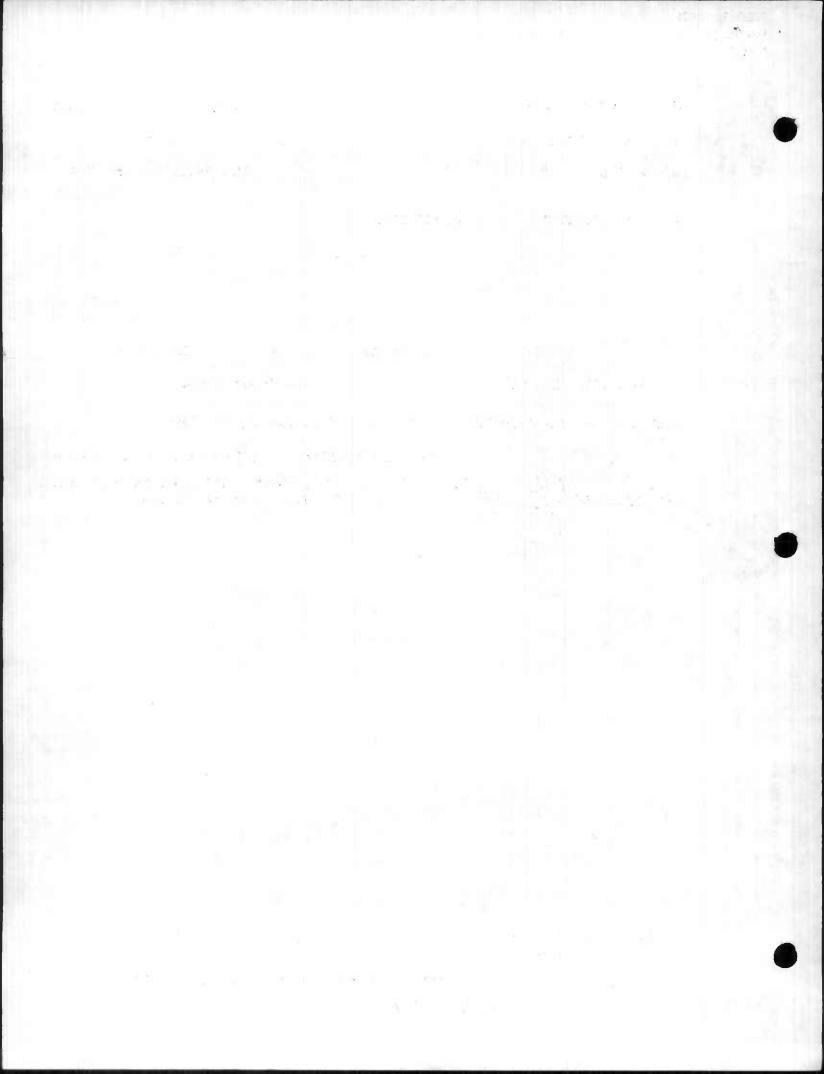
Facility Nama (If not Institution, giva : PENINSULA REGIONA Social Security Number 01-44-4998 sual Residence of Decedent la. Stata 10b. County ARYLAND WICOMICO le. Street and Number 36009 PURNELL	L HOSPITAL 7. Aga (In	yrs. last birthday 45 Yrs. c. City, Town or L	if Under Months	1 Yaar	SALISI		SOME	of Death	0605 AM	
Social Security Number 01-44-4998 1K Seual Rasidanca of Dacedent la. Stata 10b. County WICOMICO le. Street and Number	7. Aga (In	+5 Yrs. c. City, Town or L			if Undar 24					
01-44-4998 1K sual Rasidanca of Dacedent la. Stata 10b. County ARYLAND WICOMICO le. Street and Number]M 2□F	+5 Yrs. c. City, Town or L				Hrs. 8. Data of B	irth	9. Birthola		
ARYLAND WICOMICO le. Street and Number						JAN. 2	irth Pay, Year) 8,1953	NEW .	YORK	
e. Street and Numbar	CO POWELLVILLE 10f. Zip Coda 21852							100	d. Insida City Limits 1 ☐ Yas 2 💆 No	
36009 PURNELL				Coda			10g. Citizen of	Whet Countr	ry?	
			218	52			USA			
. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Moivorced	12. Was Decedant Evar Armed Forcas? 1 ☐ Yas 2 Z No If Yas, Giva Yaar or Datas:	in U,S. 13.				? (Specify Yas or N Puarto Rican, atc.)	Bia	14. Race - Amaricar Black, Whita, at Specify: WHIT		
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'. Fathar's Nama (First, Middla, Last)	LTON	CARFI	ENIER			* '	a, Maidan Suman		1	
		10b Maii	lina Addrace	(Street				Stata Zin (Code I	
								Otara, Zip C	2000)	
a. Method of Disposition 1 ☐ Buriai 2 ② Cramation 3 ☐ R	amoval from Stata	0b. Place of Disp camatary, cra	oosition (Nam am <i>atory or ot</i>	na of thar plac	ca)	Data	20c. Location			
	Belle								TY ROAD,	
nmediate Cause (Final sease or condition sulting in death)	ATHEROSCLER	OTIC CARDI	TOVASCUL						Approximata Intarval Batween Onset and Death	
equentially list conditions, any, leading to immediate suse. Enter Underlying	b. Due to (or as a consequence of):								TITE	
ast instated events sutting in death) Last	Due	Due to (or as a consequence of):								
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					24a.		4a. Was an autopsy performed?		re autopsy findings ilable prior to spletion of cause leath?	
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5. Was case referred to medical examiner?	Inenital	V-210-1-1-1-1		- I ou		Death (Check only	one)			
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3 Suicide 6 Could not be determined	28a. Piaca of Injury - building, etc. (S)	At homa, farm, s pecify)	traat, factory	, office	AND SECTION	28f. Location City or T	(Street and Numi own, Stata)	ber or Rural	Routa Number,	
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9b. Signatura and titla of cartifiar	elfell						29d. Data signe			
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State Registrar

31. Data fitad (Month, Day, Year)

32 Registrar's Signature JUL 0 8 1998



Funeral

Director

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Physician

/Medical Examiner

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Hospital or Attanding Physician: 24 hours after death. Funerel Diractor: After this certific

24 hours a

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Division of Vital Records, P.O. Box 68760.

Examiner

Physician/Medical

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Certification:

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3 Suicida

29a. Certifier

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permit. Pages 1 and 2 should be filed within 72 hours after Department of Health end Mentel Hygiene. Important: If Itam 27 Ie merked other then "natural", or ite

altimore, Maryland 21215-0020

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JESSICA E. HALLEY

Director

Funeral

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State of Maryland / Department of Health and M	lental Hygiene	Q	8	2		Q	Q	ſ
Certificate of Death	Reg. No.	200		6	1	0)	L

3. Time of Death

10d. Inside City Limits

Intervei Between Onset and Deeth

Location (Street and Number or Flural Route Number, City or Town, State) 600051K Menroe Auc

1 ☐ Yes 2 No

12:25 A

Year 1998

4c. County of Death

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ASP					Certificate of Death	Reg.
	Physician	Decedent's Name (First Jessica	t, Middle, Last) Erin	Harley		2. Dete of Death Month JUNE: 2
	/Medical Examiner	4a Facility Neme (If not in 6000 BLOCK			4b. City, Town SYKESVI	, or Location of Deeth

CARROLL If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6 Sax 7. Aga (In yrs. lest birthday) 9. Birthpiece (State or Foreign Country) Months 1 □ M 2 1 F 16 Yrs.

Feb 16 1982 MD 219-15-6473 10b. County 10a State 10c. City. Town or Location

MD Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

1718 Maryland Avenue 20764 USA 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14 Race - American Indian Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yas ZXXNo it Yes, Give Yeer or Detes: 1 ☐ Yes 2√ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) high school student 10

17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Richard Forrest Harley Theresa Lynn Cush

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. intorment's Neme/Reietlonship (Type, Print) Theresa L. Harley (mother) 14001 Coastal Highway, Ocean City, MD 21842

20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method ot Disposition 1 ☐ Buriel 2 ☐ Crametion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation 6-29-98 Hampstead, MD

21. Signeture of Funerel Sarvice Licensea 22. Nama and Addrass of Facility Haight Funeral Home & Chapel or. Have P.O. Box 195 Sykesville, MD 21784 23e. Pert1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart teiture. List only one cause on each line.

Immediate Ceuse (Finei disaese or condition resulting in deeth)

Dua to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Ware autopsy tindings aveilable prior to completion of causa of death? 24a. Was en eutopsy performed?

2 No 25. Wes cese referred to medical exeminer?
1 ☒ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6XXX ther (Specify) ROADWAY Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 ☐Neturel 5 Pending motor vehicle accident 1 Yes 2 No 6-25-98 2341 Investigation 2 Accident

28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 6 Could not be determined street

Eldersbur 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to th Cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated.

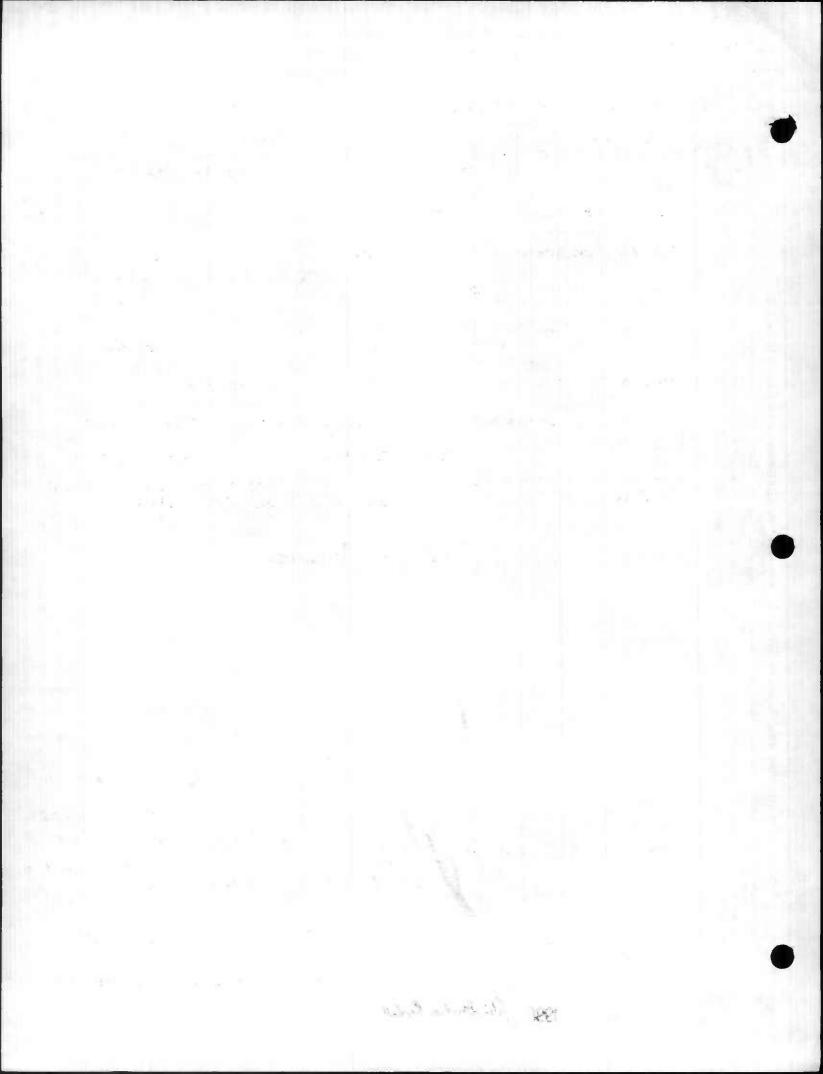
(Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Deta signed (Month, Dey, Year) JUNE 26,1998 O.C.M.E

hute me um completed cause of deeth (Item 23a) (Type, Print) 30. Name and address of person,

hutemo 111 Penn Street, Baltimore, Maryland 21201 J. Jennis

State Registrar

33 Register's Signeture JUL 0 1 1998



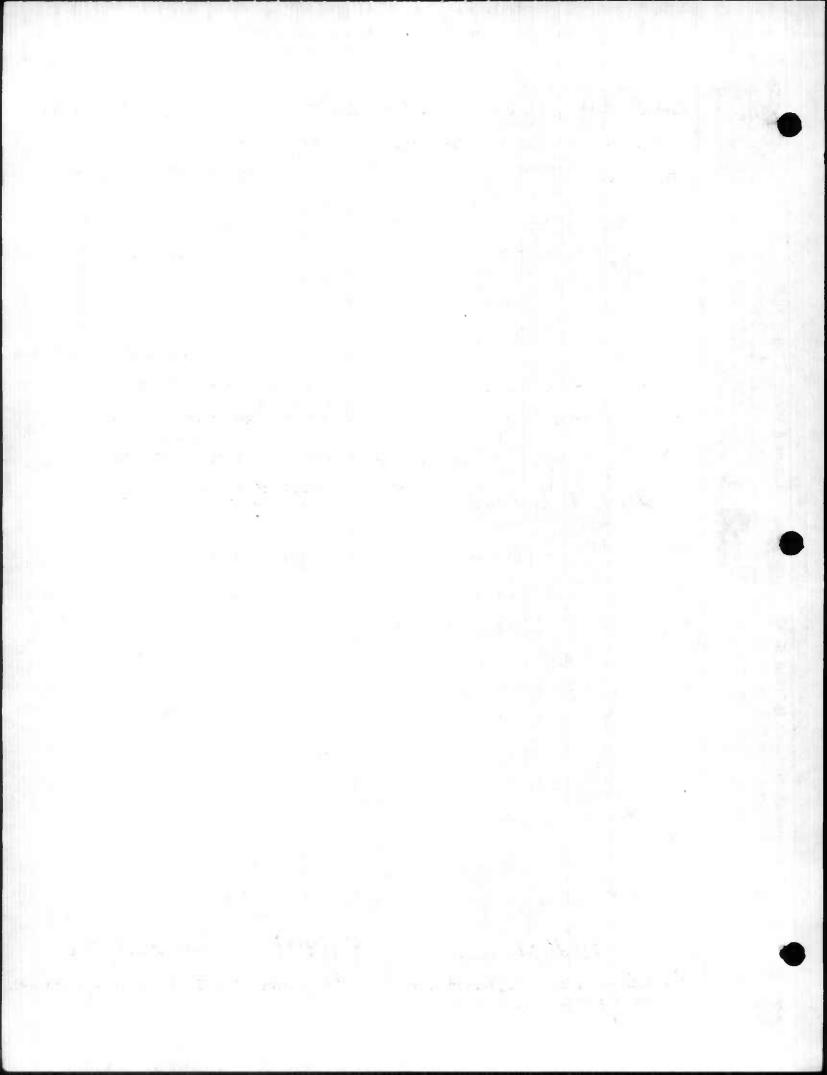
State of Maryland / Department of Health and Mental Hygiene 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month HERRING SANDRI LOUISE 28 JUINE /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner OF UNIVERSITY MARYLAND HOSPITAL BALTIMORE Months Days Hours Min. Jan. 26, 1939 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1□M 2√2F Months 59 Yrs. Director 214-36-6679 MARYLAND the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1X Yes 2□No ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 701 GLENMORE STREET 21502 U.S.A. Items 23a Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status should be filed within 72 hours after ond Mental Hygiene.
marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 MEDICINE/HOSPITAL SECRETARY 17. Fether's Name (First, Middle, Last) .. Pages 1 and 2 should be file tment of Health and Mental Hy tant: if Item 27 is marked oth jury or other traumatic even 18. Mother's Name (First, Middle, Meiden Surneme) Be ALLAN LEROY REUSCHEL EVELYN PEARL CLINE 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BRETT HERRING / SON 1321 LIMPOPO LANE, MCHENRY, MD 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or SUNSET MEMORIAL PARK 7/1/98 CUMBERLAND, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

23e. Part 1. Enter the disease, or compilidations that caused the death. Do not enter the mode of dying, such as cardlec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finei MUHI ORBAN SUSTEM FAILURE disease or condition resulting in death) Examiner Examiner The law requires that the death cartificate be axecuted burial-transit Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Lmonia Physician/Medicai the use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 9 page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? certificate of Vital Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) O_L 1□ Yes 2 No inpetient 2 ER/Outpatient 3 DOA this the funeral 27. Menner of Death Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Natural 2 Accident Division or Attending 5 Pending Investigation s after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurei Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) npleted cause of death (Item 23a) (Type, Print) 22 South Greene St, Baltimore, masson

DHMH 16 Ray 6/95

State Registrar



577-01-1710

HARDING

ELZA

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Day ELZA G. HARDING JUNE 29, 1998 /Medical 11:20P.M. 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 5. Social Security Number Date of Birth (Month, Dey, Year) Apr 16, 1 7. Age (In yrs. lest birthdey) If Undar 1 Yaar If Under 24 Hrs. Birthpiace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 577-01-1710 82 Yes Director 1916 VΆ Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Allegany MD Cumberland Director 1X Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ò 238 17 Pennsylvania Avenue 21502 Funeral USA deeth 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: Hems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, nit. Peges 1 end 2 should be filed within 72 hours after carment of Heelth and Mental hygiene. ortant: if item 27 is marked other than "natural", or iten injury or other traumatic event, the Medical Exercises. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 □ Yes 2 No by 3X Widowed 4 ☐ Divorced Specify white Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) Bell Atlantic Retired Employee 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Jacob Ernest Foster Susan (Kibler) 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Middleton-daughter 19 Pennsylvania Avenue; Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Locetion - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from Stata Department in important: if any injury or once. Arlington National Cem 4 ☐ Donation 5 ☐ Other (Specify) 07/05 Arlington, VA 21. Signature of Funeral Sen 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Finei disease or condition resulting in death) 15 DAYS PNEUMONIA Examiner Due to (or es e consequence ot): Examiner 30 YEARS COPD The lew requires that the death certificete be executed bunel-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): attending physician Physician/Medicai the Due to (or as a consequence of) ed by the at detached for Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the causa of death? been signed by should be detac 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24e. Was an autopsy After this certificate hes Attending Physician: director, Be 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manger of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Division 5 Pending Investigation 1 Naturai death. 1 ☐ Yes 2 ☐ No 2 Accident or Attend efter death Director: / filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 HomicIde To the Hospital within 24 hours e Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifie 29b. Signature and titia of certifier 29c. Licansa numbar 29d. Date signed (Month, Dev. Year)

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State Registrar

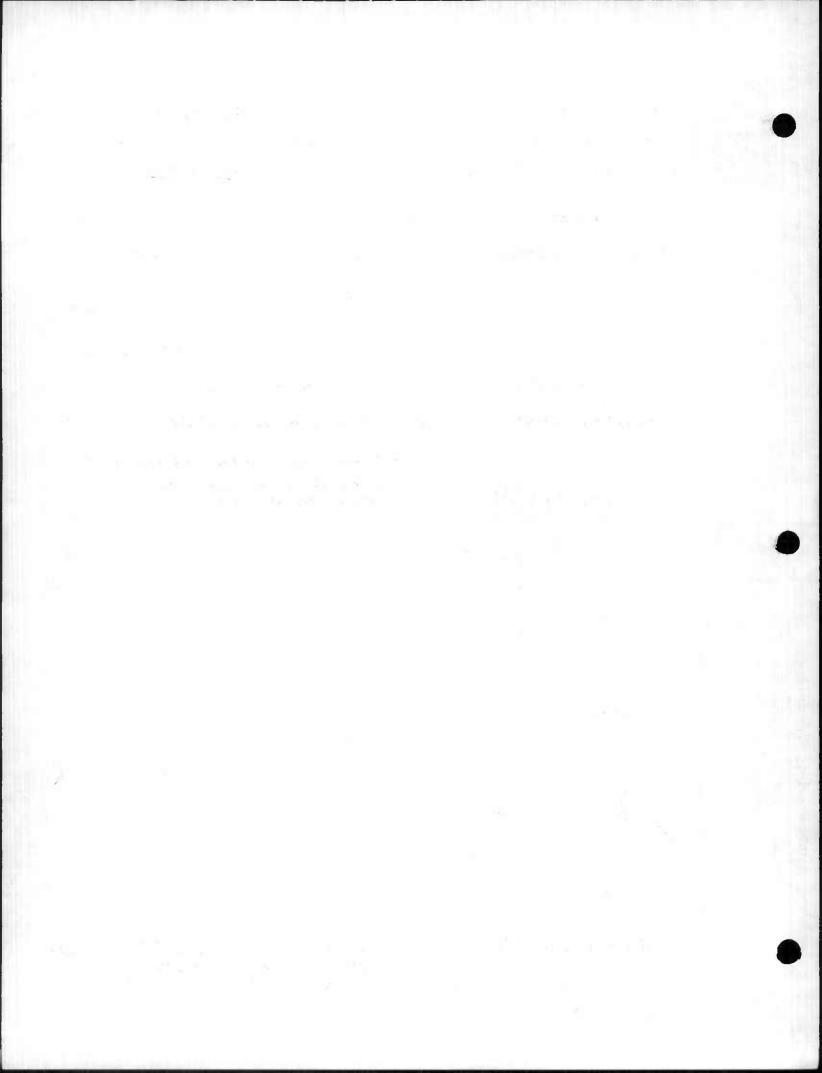
DR. HUMA SHAKIL, Johnson Heights Medical Building Cumberland, MD 31. Date filed (Month, Day, Year)

JUL 0 1 1998

Hmashalil

32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue, Suite 304



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Pauline A. Hillegas 30, 1998 0400 a.m. JUNE 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street and number) Cumberland Sacred Heart Hospital Allegany ff Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. July 6, Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2 TF 89 Vrs Pennsylvania

Funeral Director

Physician

/Medical

Examiner

5. Social Security Number

175-20-0702

28a-fs Director than "natural", or items 23s or the Medical Examiner must be r Funeral à Completed Be

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P.O. Box 68760. Division of Vital Records, • Euneral Director: After details in Funeral Director: After details in by the fun To the Hosp within 24 hor To the Fune completely fi

Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No PA Somerset Boynton 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code Post Office St. 15532 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Maritai Stetus Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: white 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 th Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Boaz Trent Savilla Garlitz 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) 230 Fike Hollow Rd., Meyersdale, PA 15552 R. Dean Hillegas/son 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method ot Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State July 3, 1998 Salisbury Cemetery, Salisbury, PA 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Newman Funeral Home, Inc., 21. Signeture of Fugerel Service Licenses de P.O. Box 116, Salisbury, PA 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximete fntervel Between Onset end Deeth lenke mia Immediate Cause (Finei disease or condition resulting in death) Week. Due to (or es e consequence Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of).

Pert ft. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Delydration Failure. Congestive heart Failure

24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy performed? completion of cause of death? 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical exeminer? 28. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpetient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturei 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide

29e. Certifier 1 ☑ Certifying Physician: To the best ot my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner steted. 29c. License number 29b. Signeture end title of certifier

29d. Dete signed (Month, Day, Year)

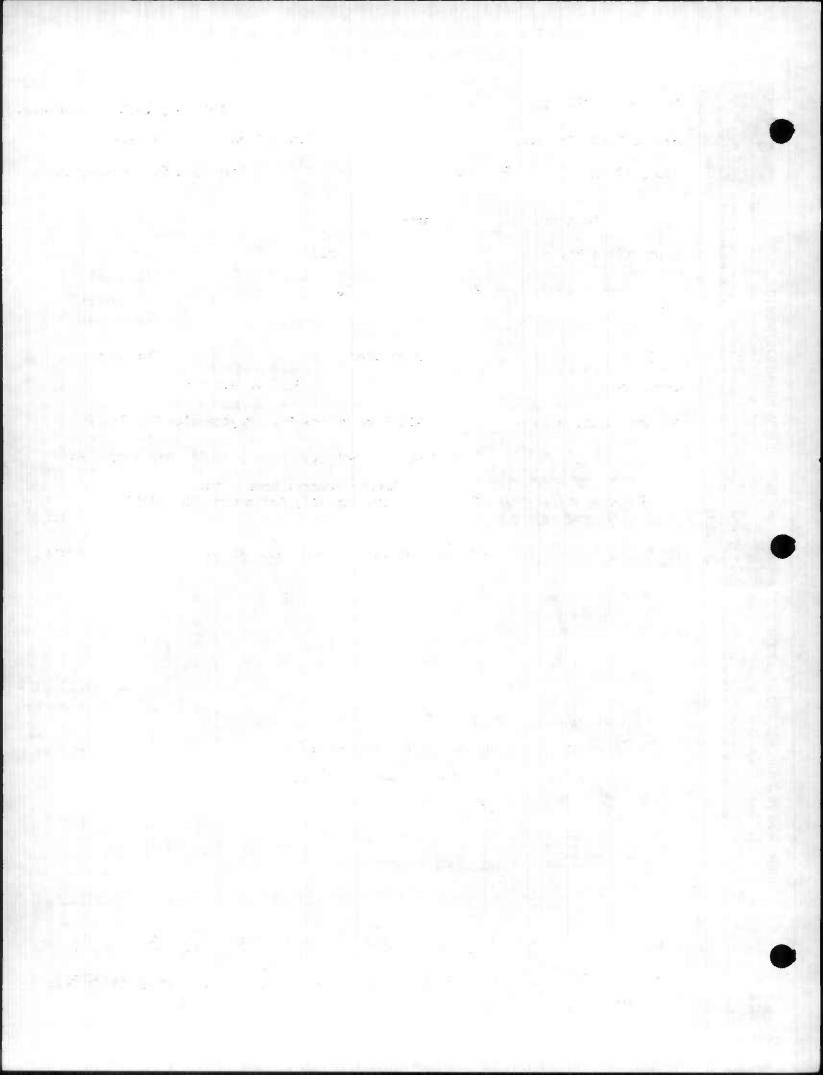
23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)

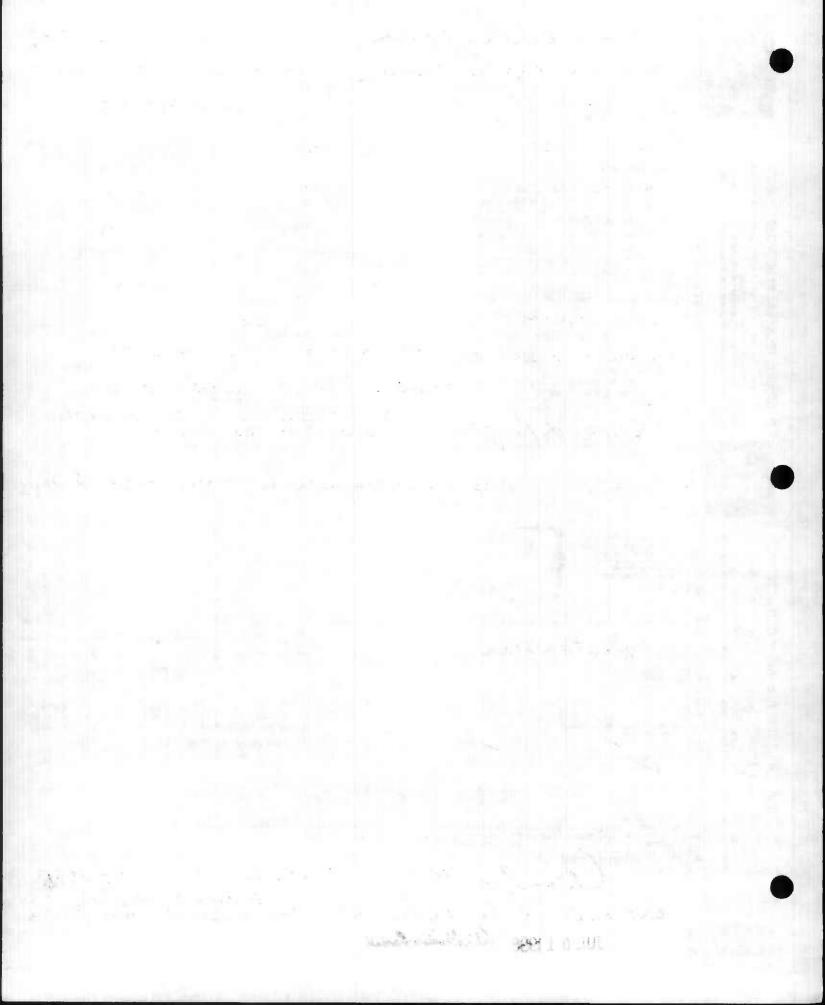
Terrace Frostburg, MD 21532 bandhir 92. Registres's Signeture

State Registrar



State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death JAMES **Physician** KANE 5;15 My JUNE /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Baltimore Randallstown | H Undar 1 Yaar | H Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Sept. 23 1920 MD 7. Aga (In yrs. last birthday) Yrs 5. Social Sacurity Number Birthpleca (Stata or Foraign
 Country) **Funeral** 1∭ M 2□ F Months 213-01-5478 **Director** Usual Rasidence of Decedant the Maryland 10b. County 10c. City, Town or Location Sykesville 10a. Stata 10d. Insida City Limite 28a-f ahow 7 is merked other than "natural", or frems 23a or 28a-f shot traumatic event, the Medical Examiner must be notified as MD Carroll 1 Yas 2 No Directo 10g. Citizan of Whet Country? USA 10e. Street and Number 10f. Zip Coda 21 784 5501 Crows Nest Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a any Injury or other traumatic event, the Medical Experimentage. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ⊠ Yas 2 □ No 1942-If Yas, Giva Yaar or Datas: 1945 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: Specify: white à 3 X Widowed 4 ☐ Divorced 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working life. DO NOT usa retired) Elemantery/Secondary (0-12) College (1-4or 5+) retail sales manager Hess Shoes 18. Mothar's Nama (First, Middle, Maiden Sumama, 17. Fathar's Nama (First, Middla, Last) Julia Olivia Grueber Jerome Kane 19b. Mailing Addrass (Street end Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 131 Brass Eagle Dr. Sykesville, MD 21784 19a. Informant's Name/Ralationship (Type, Print) Thomas Kane (son) 20b. Plece of Disposition (Nama of cemetary, crametory or other place)
Garrison Forest VA Cem. Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 7-2-98 Owings Mills, MD 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licansas Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complication. Unit caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate tntarval Batween Onsat and Death **Physician** 6 heall Immediata Causa (Final disaasa or condition resulting In death) /Medical Scolla seal Examiner Physician/Medical Examin ettending physician and for use es the burial-transit executed Sequantially list conditions, if any, laading to Immadiate causa. Entar Undarlying Ceuse (Diseese or Injury that initiated evants rasulting In daath) Last Dua to (or as a consequence of) Box 68760. The law requires that the death certificate be Dua to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. the 3 1 Yee 2 N6 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed peen complation of causa of daath? page 2 certificate has 1 Yes 2⊞No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was casa rafarrad to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 (Inpetient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) OL 1 Yas 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After this 28a. Data of Injury (Month, Day Year) funeral 28c. Injury et Work? 27. Menner of Death 28d. Dascribe how Injury occurred 28b. Tima of Certification: or Attanding 5 Pending 1 Natural 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant the 6 Could not be detarmined 3 Sulcida 28a. Plece of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicida 29a. Cartifiar 1 Cortlying Physician: To the best of my knowledge, daath occurred at tha tima, data end placa, and dua to tha causa(s) and manner as steted.

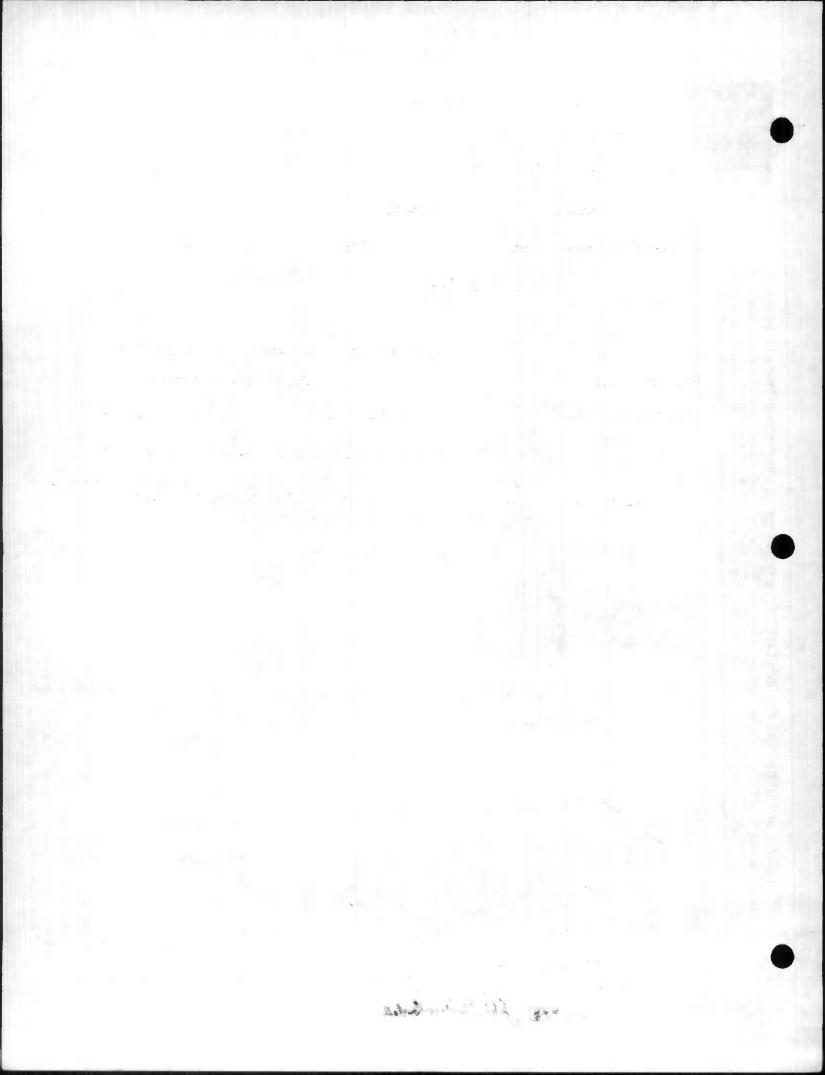
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the time, data and place, and due to the causa(s) and manner stated. edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Data signad (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of mo. Jauo RANDALLSTOPPA 2/133 Print) OLD COURT RD 1

State Registrar 3. Registrar's Signature

30. Nema and addrass of parson who somplated causa of death (Itam 23a) (Type, Print)

Day, Yaar)

JUL 0 1 1998



					(Certificate of	Death		Reg. No.	
	- 201		1. Decedent'e Neme (First, Middle, La	ist)				2. Dete of De	eth	3. Time of Deeth
	Physici /Medic		Mildred Ar	nne Knigl	ht			June	26, 19	98 7:00 pm
	/wedir		4e. Facility Neme (If not institution, given	0			4b. City, Town, or L			
7			Calvert Cour	nty Nursi	ng Cent	ter	Prince Fr	rederick	Cal	vert
	Funerai		5. Sociel Security Number 6. 5	Sex 7. Age	(In yrs. last birth			8. Dele of Bir (Month, De	th Vens	Birthplece (Stete or Foreign Country)
	Director		220 74 6336 Usuel Residence of Decedent	1□M 2⊠F 9(0 Y	s. Months Days	Hours Mill.	Sept 11	1907	VA
	d within 72 hours after death with the Maryland liene. Then "naturel", or flems 23a or 28a-f show the Modical Exeminer must be notified at	Funeral Director	10e. Stete 10b. County Calve	ert	10c. City, Town	or Location Pr	rince Fred	lerick		10d. Inside City Limits 1 ☐ Yes 2X No
	th th	Sire.	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Whet Country?
	23a	le	85 Hospital Roa	d		20678			US A	l .
	en de	Jue	11. Merilei Stetus	12. Wes Decedent Ex Armed Forces?	ver in U,S.	13. Was Decedent of it Yes, specify Cub	Hispenic Origin? (Spoan, Mexican, Puerto	ecify Yes or No		a - American Indien, k, While, etc.
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	and selth		Ralph W. Knight		PO	Box 67	Sunderlan	d, MD	20689	
Baltimore,	permit. Peges 1 Department of He important: If iten any injury or oth		20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specie		Ft. L1	Disposition (Name of cremetory or other ple NCOIN CEME	tery	7-1-98	Brentwo	City or Town, State
alti	mit. partiti porta / Inju		21. Signature of Funeral Service Lice	nsee () ()		22. Name end Addr	ess of Fecility			
8	88558		1/1/ Weam of	Them		Rausch Fu	neral Hom	e, Owi	ngs, MD	20736
	-		23a. Part I. Enter the disease, of com shock, or heart failure. List only	plications that caused t	he deeth. Do no	t enter the mode of dy	ing, such es cardiec	or respiretory e	rrest,	Approximate Interval Between
	Physician /Medical Examiner	Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions,	b	Oue to (or es e co	nsequence of):	wcf) O	RGA~1C	BRANS	Y-Monf-Yrası
30,	icate be executed physician and s the burial-transit		if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury		20 10 (01 03 0 00					
Box 68760,	tha deeth carificate be executed y the attending physician and ached for use es the burial-transit	in/Medical	that initieted events resulting in deeth) Lest Due to (or es e consequence of):							
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Division	of or Attending after death. Director: After d in by the fundant	Certification:	3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of niner: On the basis of e end menner stete	xeminetion end/	deeth occurred et the ti or investigetion, in my	me, dete end pleca, opinion, deeth occur	end due to the red et the time,	cause(s) and ma dete end plece, e	nner as stated. and due to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** 1998 8:00 p.m. July Rudolph J. Kompanek /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Death Examiner Memorial Hospital & Medical Center Allegany Cumberland If Undar 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (Stete or Foreign Country) **Funeral** Days 1 M 2□ F Months Hours Yrs. 86 Director 1912 705-07-9685 Jan 6, Penna Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intt if them 27 is marked other than "natural", or items 23s or 28s-1 show 10d. Inside City Limits 10a Stata 10b. County 10c. City, Town or Location Cumberland 1 X Yes 2 □ No Maryland Allegany Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be 21502 USA 625 Frederick Street Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Naver Married 2 Married **SpeciWhite** Baltimore, Maryland 21215-0020 1 ☐ Yes ¾☐ No Specify: þ 3 □WIdowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Rail Road Superintendent 9 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middla, Last) Mary A. (Sabo) Andrew J. Kompanek, Sr. 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 11818 Messick RD, Cumberland, MD21502 Judy Hager 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o W Burial 2 ☐ Cremation 3 ☐ Ramoval from State 7/7/98 Cumberland, MD Sunset Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furent Service License 22. Nama and Address of Facility Kight Funeral Home 309-311 Decatur St., Cumberland, 23a. Part1. Enter the disease, or complications that cau ad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequenca of) Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in daath) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): 80 23b. Did tobecco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 | Yee 2 | No signed t p 24b. Were autopsy tindings available prior to complation of causa of death? been signal Completed 24a. Wes an autopsy performed? page 2 certificate has 1 Yes 2 No 1 Tyes 2 No Hospital or Attending Physician: 24 hours aftar death. Funeral Director: After this certifica the funeral director, Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2210 → Inpatient 2 ER/Outpatient 3 DOA Certification: To 705-07-9685 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred Neturel 5 Pending 1 ☐ Yes 2 No Investigation 2 Accident To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, ferm, straat, factory, office building, etc. (Specify) 28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 29c. License number 1998 en D 28910 July 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Curtiss Merrick, M.D., Memorial Hospital Medical Building, Cumberland, MD 21502

State

Registrar

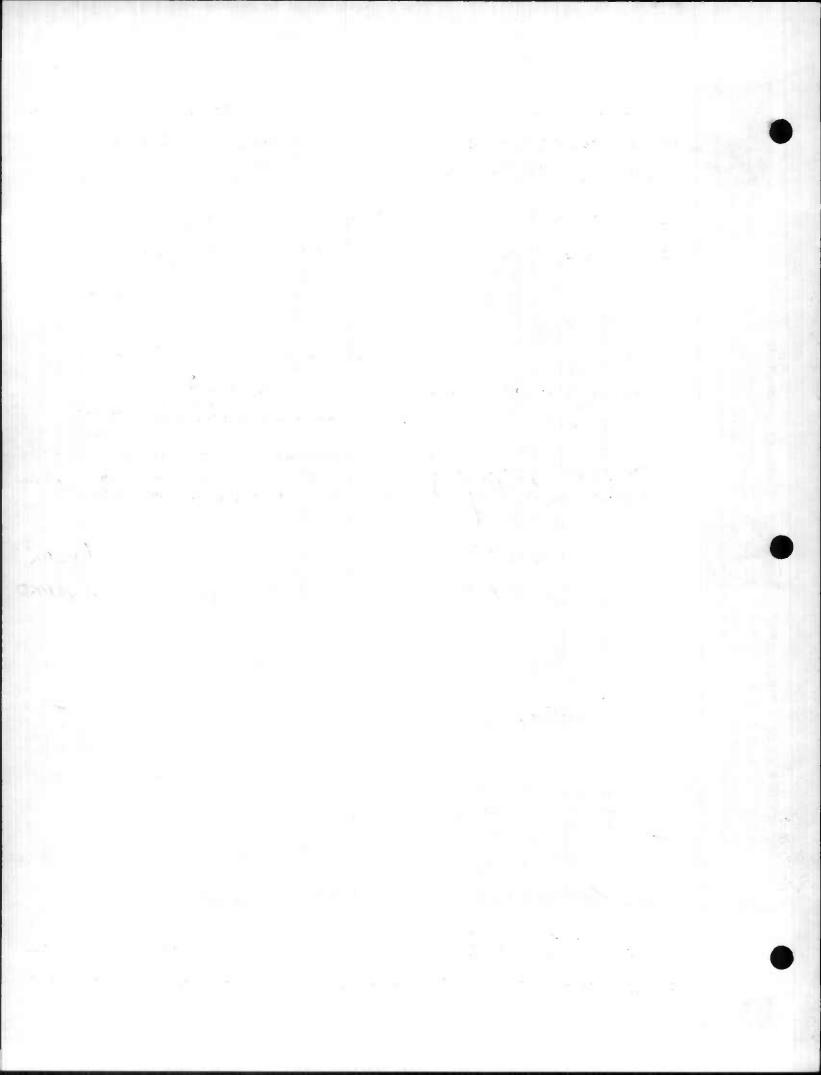
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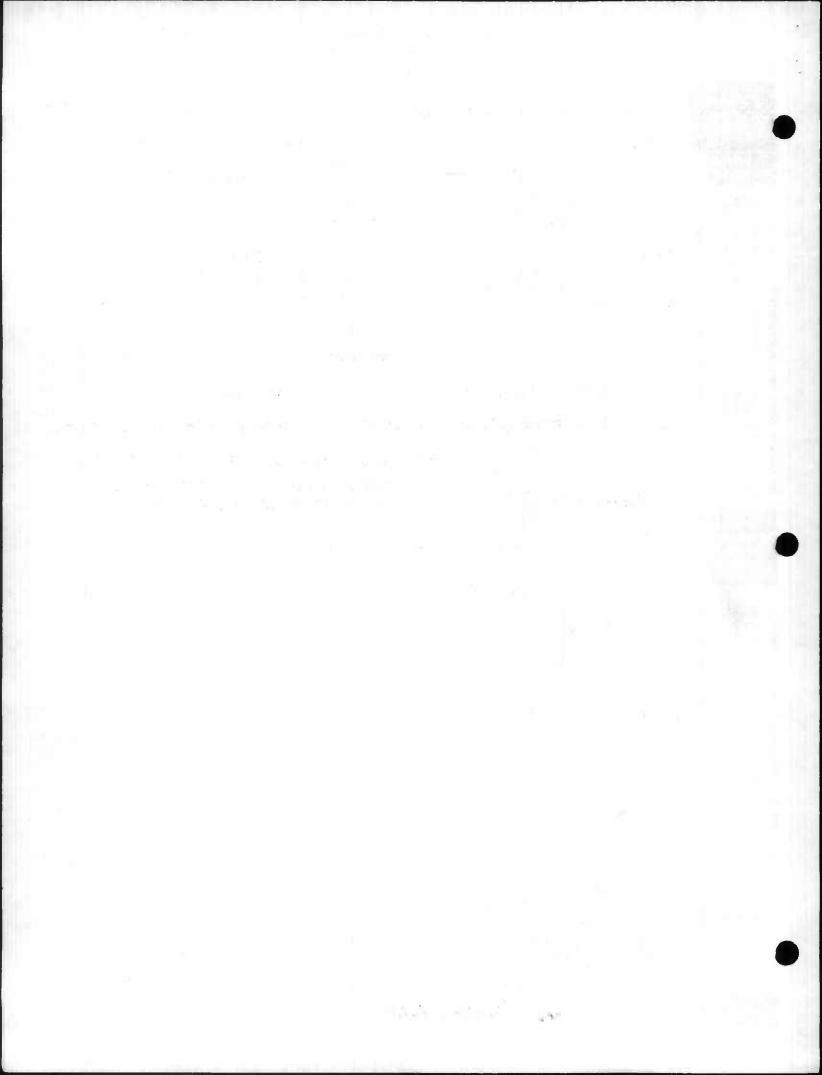
Rudolph Kompanek



Amended Item #7 per Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. F.H., Amended Item #26 per State of Maryland / Department of Health and Mental Hygiene () Phy, 7/2/98, Carroll County, wil Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** Month Bernice Elizabeth Lichtenegger June 29 1998 5:30pm /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harmony Hall Columbia Howard If Under 1 Yaar | If Undar 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 1□M 2√2F 80 81 Yrs. Director 215 05 2409 Usuel Residanca of Decadant Aug 23, 1916 | North Dakota the Marylend 10a. Sleta 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yas 2 No Director MD Howard Columbia 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 6 6336 Cedar Lane 23a 21044 Funeral U.S.A. 14. Raca - Amarican Indian, Bleck, Whita, atc. items i 12. Was Decedant Evar in U,S. Armad Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Maritel Status 2 should be filled within 72 hours efter on the Mentel Hygiene. Is marked other than "naturel", or ite 1 Navar Married 2 Married 1 ☐ Yes 2 No If Yas, Giva Yaar or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by Specify: White 3√ Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantery/Secondary (0-12) Coliege (1-4or 5+) 12 Secretary Clerical 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) permit. Peges 1 and 2 should be Depertment of Health and Mentel Important: If item 27 is marked any injury or other traumatic av 2008. William Wolfgang Wagner Meta Kuecks 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Stete, Zip Code) 21158 19a. tnformant's Neme/Reletionship (Type, Print) Mrs. Hazel C. Wagner (sister-in-law) 1256 South Pleasant Valley Rd, Westminster, MD 20b. Plece of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Serv. 6/30/98 Hampstead, MD 22. Nama and Addrass of Fecility HAIGHT FUNERAL HOME & CHAPEL (Box 195) 21. Signatura of Funeral Sarvice Licansas Duar L Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onset end Death **Physician** Immediata Cause (Final disaase or condition rasulting In daath) /Medical Cohorum Anton Examiner Ventrul on fluis Examiner the buriel-trensit the death certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disaasa or Injury that initieled avents pue Dua to (dr es e consaquence of): Box 68760 physician Physician/Medical thet initieted avents resulting in death) Last Due to (or es a consequança of): ettending p 98 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown 9 Cevelul Ussilm Division of Vital Records. 24b. Wara autopsy findings availabla prior to complation of cause of deeth? 24a. Was an autopsy performed? Completed peen 390 2 KNO 1 Yes 1 ☐ Yas 2 ☐ No certificate 25. Wes casa raferred to madical axaminar? Assisted Living Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ inpatient Othar: $4\square$ Nursing Homa $5\square$ Rasidence 6 **M**Othar (Specify) **Facility** 1 ☐ Yas 2 No 2 Proupation 3□ DOA 27. Manner of Deeth 28d. Dascribe how Injury occurred he Hospital or Attending P in 24 hours efter death.

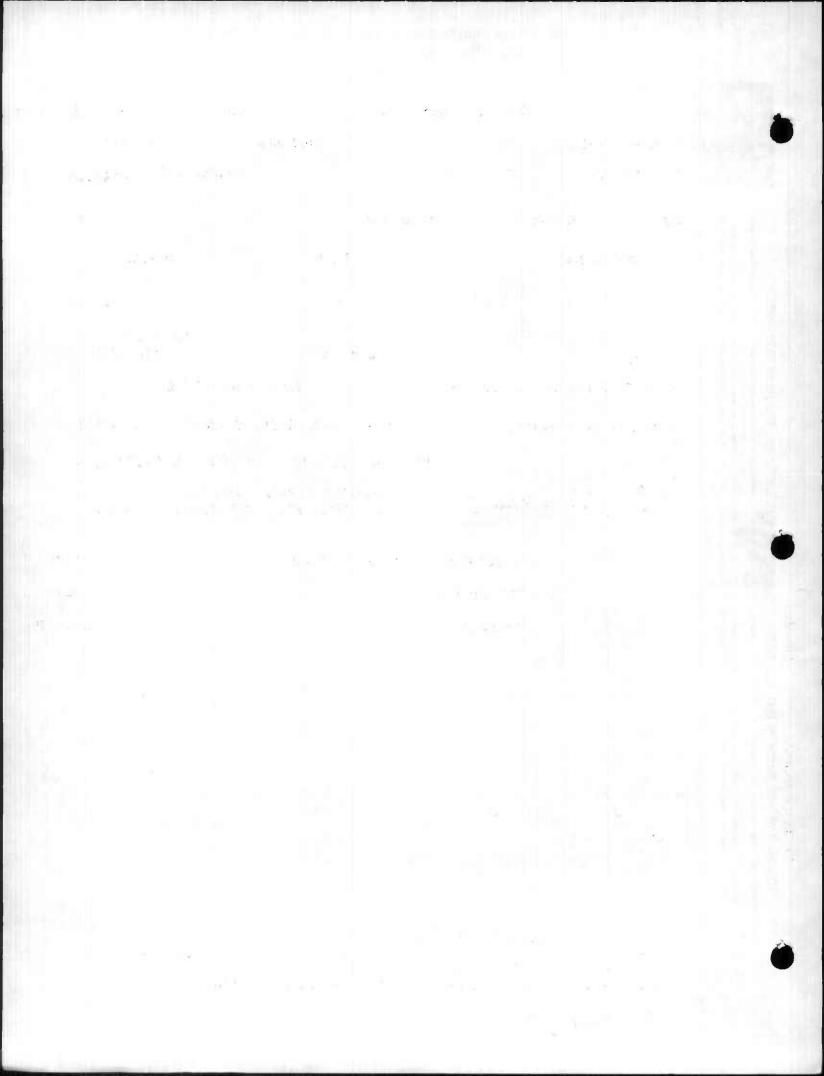
he Funeral Director: After tipletely filled in by the funeral Certification: 28c. Injury at Work? After 5 Pending Investigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 ☐ Could not be determined 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicida 29a, Cartifier Certifying Physician: To the best of my knowladge, death occurrad et tha time, date and piece, and due to the ceuse(s) end mannar as stated. (Check only one) 2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and piece, end due to the causa(s) end manner stated. within 2 To the F 29b. Signature end titla of complian 29d. Data signed (Month, Day, Year) 30. Neme and addrass of person who completed cause of death (item 23e) (Typa, Print) LITPUL PATURUT PIL Coluction, MIS Ser Durco 1/017 31. Data filed (Month, Day, Yaar) State Registrar

DHMH 16 Ray 6/95



DHMH 16 Rev 6/95

Registrar



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State of Maryland / Department of Health and Mental Hygiene

				Cei	tificate of	Death		Reg. No.	21901			
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/Med Exami		4e. Fecility Neme (If not Institution, give			[4b. City, Town, or Lo	JUL ecation of Deetl	121	10			
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Funeral Director		203 70 0300	7. Age (In y	rs. last birthdey) Yrs.	If Under 1 Year Months Days		8. Dete of Bir (Month, De Jan.	th y, <i>Year</i>) 30 1902	9. Birthplace (State or Foreign Country) Maryland			
and we		Usuai Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits			
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		30. Name end eddress of person who co	mpleted cause of deeth (I	_	Print)	Arran 1	.00 . 0	A (MIL)	MPAN MINS			
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Walter Commencer

WRC 98-3807-009 BYRON CHARLES S.McANIEL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical	
Examiner	ŀ
	Į

Funeral Director

with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show sur higher or other treumstic event, the Medical Esseline must be notified at page.

Physician /Medical Examiner

altimore.

attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760. ed by the a signed by t Division of Vital Records, peen certificate has b Hospital or Attending Physician: this funeral After To the Hospital or Attendifulin 24 hours after death.
To the Funeral Director: All completely filled in by the fu death.

1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3 Time of Death Day Month 01, 1998 Byron Charles Seaton McDaniel JULY 6:00 PM. 4a Facility Nema (If not institution, give street and number) HUNTINGTOWN

Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Yeer)

Mar 31, 1952 4b. City, Town, or Location of Death 4c. County of Death Calvert 2130 LOWRY RD. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1QM 2□ F Yrs 46 VA 225 64 3195 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits MD Calvert Huntingtown 1 ☐ Yes 2 🖾 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2130 Lowery Road 20639 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried white 1 Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) welder local government 17. Fathar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) McDaniel Josephine Herrington Seaton 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Brian C. McDaniel/son 13491 Higgs Ct., Herndon, VA 20171 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 7-6-98 Southern Mem. Gardens Dunkirk, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fugeral Service Light 22. Name end Address of Fecility Rausch Funeral Home, Owings, MD Fart1. Enter the disaese, or complications that shock, or heert failure. List only one cause on each ha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death fmmediate Ceuse (Finel diseese or condition resulting in deeth) Cardiovascular Due to (or es a consequence of) Physician/Medical Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert fl. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Ptycknown labetes mellitus by 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home XXResidence 6 Other (Specify) XXYes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Neturel 5 Panding 1 □ Yes 2 □ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Streat end Number or Rural Route Number, City or Town, State) 28e. Pleca of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

**Continuous of the deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

**Continuous of the deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number O.C.M.E. JULY 02, 1998 20 30. Neme end address of person why completed cause of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar hute

32. Registrer's Signeture

Jalia Stevelson Rostall

Dennis J 31. Dete filed (Month, Day, Year)

3 - W marin 200 5 1 199

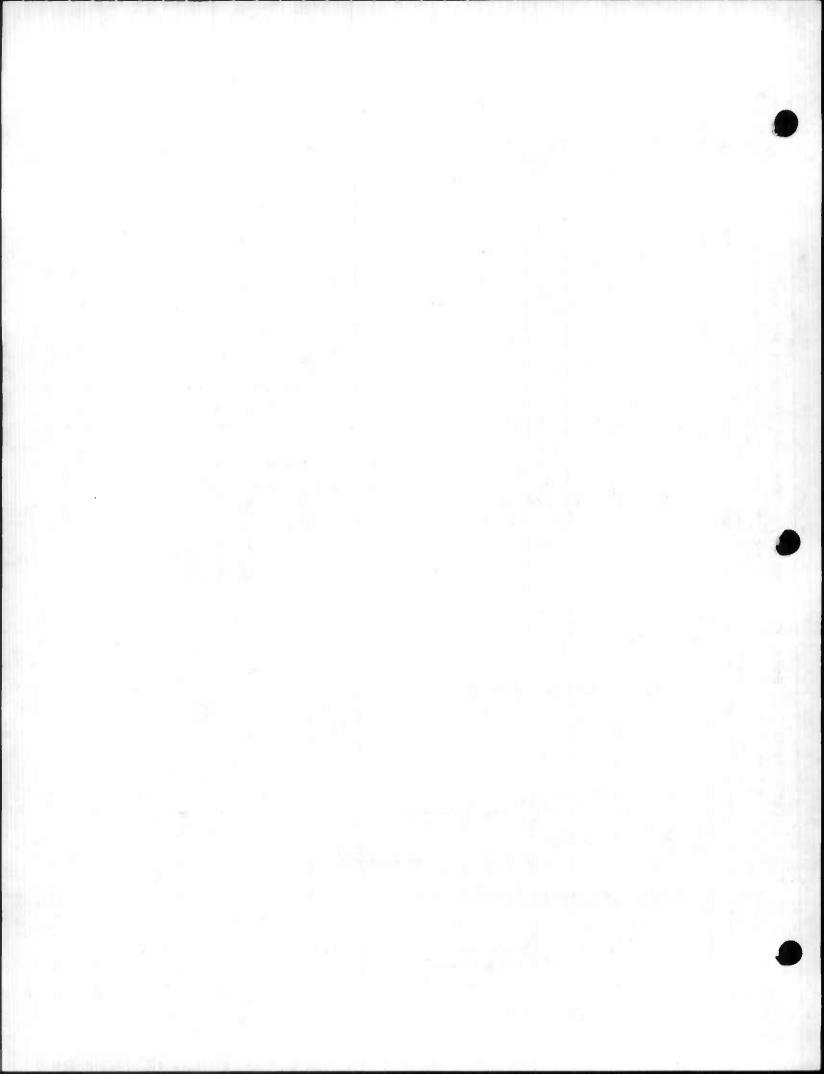
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State of Maryland / Department of Health and Mental Hygiene ()

						Certific				Reg. No.) 41	903	
r	Physici	an	Decedent's Neme (First, Middle,						2. Dete of De Month	eeth Dey	Year 3.	Time of Death	
	/Medi		Francis Elsi						6	29		:30 pm	
	Examir	ner	4e. Fecility Neme (If not institution,				4	4b. City, Town, or	Location of Deel	th 4c. County	of Death		
			8913 Erie Ave				der 1 Yeer	North F		Calv			
п	Funeral Director			1 M 2X0 F	ge (In yrs. Ia 52	Yrs. Monti		Hours Min.	(Month, D			(State or Foreign	
			578-64-0583 Usuel Residence of Decedent		- 52				3/31/	46	Washin	gton, D.	
	yland		10a. State 10b. County		10c. City,	Town or Location					10d. lr	nside City Limits	
	Mar	to	MD Calve	rt	NO	rth_Beac	rh.		1 Tyas 2				
	h tha	Director	10e. Street end Number	1.0	11101		Zip Code						
	h wit		8913 Erie Ave				20714	-0783					
	dea	Funeral	11. Meritel Stetus	el Stetus 12. Wes Decedent Ever in U,S. 13 Armed Forces?				lispanic Origin? (S en, Mexican, Puer	Specify Yes or No	USA 0- 14. Rec	ce - American Inck, White, etc.	dien,	
0	or h	F	Never Merried 2 Merrie				2]X] No		to ritoan, orc.)	Specifi			
00	n 72 hours aftar death with the Maryland "neturel", or Herm 23a or 28a-f show solpell Exercine from the notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Yeer or Detes:							whi		
21215-0020	C 1 10	Completed	15. Decedent's (Specify only highest	Education grade completed)		18a. Decedent's U (Give kind of	work done	eation during most of wo d)	rking	16b. Kind of B	usiness/Industry		
212	within iene. then "	шс	Elementery/Secondery (0-12) 1 2	College (1-4or	5+)			2)		- la		-56:	
	other of	BeC	17. Fether's Neme (First, Middle, Li	nst)		DOOKKEE	eeper physician's of					orrice	
Maryland	s i and 2 should be filed if Health and Mental Hygitem 27 is marked other other traumatic event,	To B	Edgar Miller				Eva Louise McCulley						
ary	2 should be and be is man		19s. Informent'e Neme/Reletionshi	p (Type, Print)		ess (Street	end Number or R				9)		
	i and 2 Health o		Christin Irvi	ng		1911 На	rcou	rt Ave	. Croft	on, MD	21114		
ore	ges 1 and it of Health if item 27 or other tr		20a. Method of Disposition 1 □ Burial 2 【XCremetion 3	Demonal from State		nce of Disposition (I	Neme of		Dete	State			
Ĭ	artment of ortant: If the injury or o		4 □ Donetion 5 □ Other (Spe			ropolita	n	7/2/98	Alex.	, VA			
Baltimore,	permit. Page: Department of important: if i eny injury or ance.		21. Signeture of Funeral Service Li	censee				ss of Fecility		Funera			
Ш	20 E 2 9		Muchell	9. Kain	55	P.O.	Box	121, 1	_	. 9			
			23a. Pert1. Enter the disease, or c shock, or heart feilure. List or	omplications that cause	d the deeth.	Do not enter the m	node of dyln	ng, such es cardie	c or respiratory	errest,	App	roximete rvel Between	
	Physician										Ons	et and Deeth	
4	/Medical Examiner		Immediate Cause (Finel disease or condition resulting in deeth)	. Ische	emic	Cardio	my	opathy					
		-	Tooling it doding		Due to (or	es e consequence	of):	2					
	nsit	Examiner		■ b. 14pe				Mellet	ひ		1		
Ć,	tificata be axecuted ig physician and as tha burlat-transit	Exa	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events	(1	Due to (or e	es e consequence	of):						
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	tifical ag ph	Med	resulting In death) Last		000 10 (01 0	o o consequence c	,,,				i		
Box	h cer endin	Physician/M		d							i		
	the death y the atter	sici	Pert II. Other significant condition	contributing to death b	out not result	ting In the underlyIn	g cause giv	ren in Pert I.	23b. Dld	tobacco use co	ntribute to the	cause of death?	
P.0	that the death cer ned by the attendir detached for usa	Phy							10	Yes 20 No	3 Probably	4 Unknown	
	A G. S	by											
Records,	v requires been sign should be	Completed								an autopsy omed?	availeble	utopsy findings e prior to	
ec	as t	nple									of death	ion of cause	
E		ပ္ပ							10	Yes 2 No	1 ☐ Yes	2 No	
Vital	Physician: The I this certificata ha	Be	25. Wes case referred to medical examiner?	Manage de la companya			1 -00		eth (Check only	one)			
o	Physic this o	2	1 Yes 2 No	Hospitel: 1 Inpatie			DOA Oth	4 LI Nursing I	lome 5 Res		ner (Specify)		
LO	After funer	lo	27. Manner of Death 1 Neturel 5 ☐ Pending	28a. Dete of Inju (Month, De	y Year)	28b. Time of Injury M	28c. Injur		28d. Describe	how Injury occur	red		
Sic	or Attending aftar death. Director: Aftai In by tha fune	lcat	2 Accident investige 3 Suicide 6 Could no	be on Diagratic	iun, At horr	ne, ferm, street, fect	1	Yes 2 □ No	28f Location	(Street end Numl	her or Rural Rou	ite Number	
Division	or Attendate after deat Director:	Certification:	4 ☐ Homicide determin		c. (Specify)	10, 101111, 511661, 1661	iory, onice			wn, State)	or or marai mod	to rearribor,	
	apita nours nerei		29e. Cartifier 12 Certifying	Physician: To the best	of my knowl	edge, deeth occurre	ed et the tin	ne, dete and place	e, end due to the	cause(s) and me	enner ss stated.		
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After thi completaly filled in by the funeral	29e. Cartifier (Check only one) 29e. Cartifier (Check only one) 29e. Cartifier (Check only one) 20						pinion, deeth occu	urred et the time,	dete end plece,	and due to the	euse(s)	
	To the To the Comp	29b. Signature end title of certifier						1	29d. Dete signe	d (Month, Dey,	Year)		
	10 Julie O'Keefe 120 Hospital Road Stute 200 Prin						Dul	1,190	18				
	10		30. Name and address of person w	o completed cause of c	leeth (Item 2	23e) (Type, Print)				Vd	1		
			Julie O'Keef	e 120 H	ospita	al Road	x Su	ute 200	> Prin	ce Fred	derick.	MD	
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registr	ar's Signetu	re . O a	**					20678	

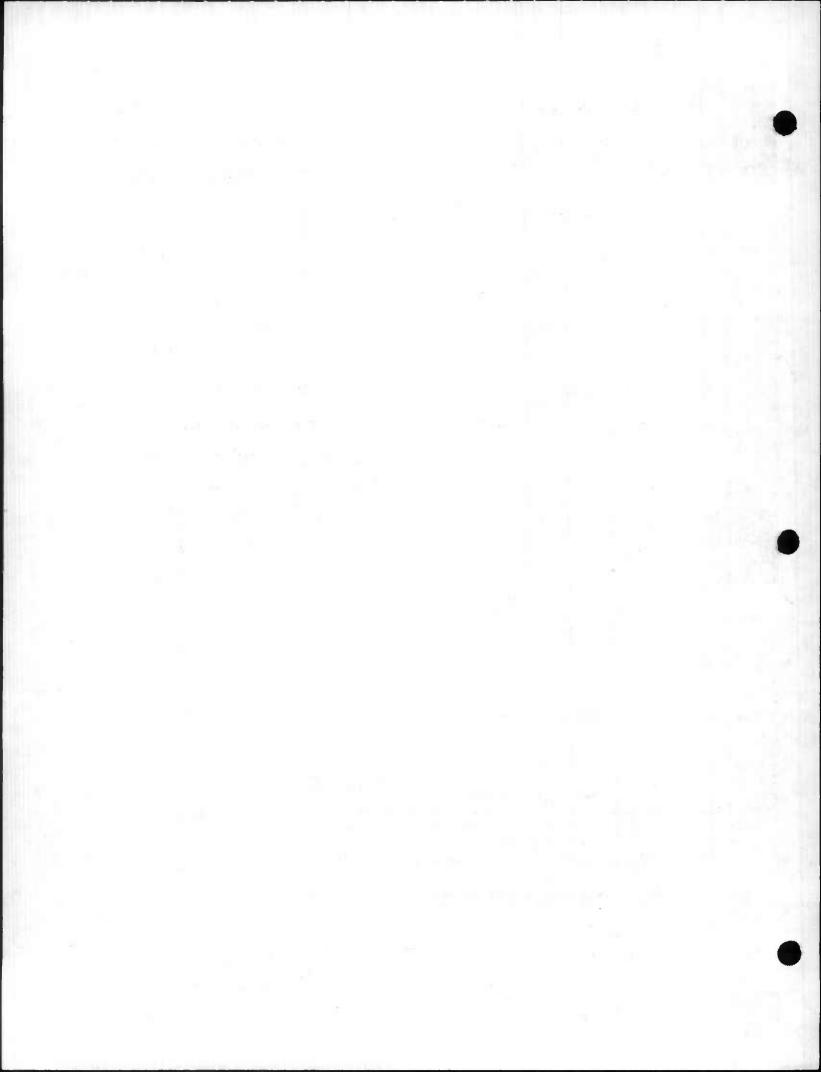
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physic		1. Decedent's Name (First,	Middla, La	st)			ertificate of	Dealli	2. Date of De	Reg. No.	3.	Time of Death
		Gilber	t	j	No1and		Murray		Month	Day	198 C	600
/Med Exami		4a. Facility Nama (If not ins	titution, giv					4b. City, Town, or L	-	h 4c. County	110 -	
		Queen City	Tower	s Pa	ca St.			Cumber1a	nd	Alleg	anv	
Funeral Director		5. Social Security Number 219-26-9164 Usual Residence of Deceding	6. S		7. Aga (In yr. 59		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 12	th ly, Year)		(Stata or Foreig
how		10a. State 10b. C			10c, C	City, Town or	Location				10d. ir	nside City Limit
1	cto	MD A	llega	ny		Cumbe	rland				1	¥ Yas 2□N
or 2	olic	10e. Straat and Number					10f. Zip Code			10g. Citizen of V	Vhat Country?	
23a	<u>a</u>	Queen City	Tower	s Pac	a St.		21502			U.	S.A.	
it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itema 23a or 28a-f show or other traumatic event, the Medical Evaluation must be notified at	by Funeral Director	11. Marital Status 1 XNever Married 2 3 Widowed 4 Div		Armed Fo	2 No	u,s. 1. 960 963	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No		pecify Yas or No Pican, atc.)	14. Race Blace Specify	e - American in k, Whita, atc. White	
- 40	Completed	(Specify only Elementary/Secondary (C		ucation da com <i>pleted)</i> Cotiege (16a. De	cedent's Usuai Occup ive kind of work done b. DO NOT use retired	during most of world)	king	16b. Kind of Bu	usiness/Industry	1
Ner th		12					Labore			Handyma		
d off	Be	17. Father's Name (First, M	,	T 1 1		3.6		18. Mother's Nam				
Merke natic	2	Kendall		Leland		Murr		Rosalie		Bertha		rkierv
r is n		19a. Informant's Neme/Rei					ailing Address (Street					
Department of Health and Mental Hygiene, Important: if Item 27 is marked other than any fujury or other traumatic event, the M pnce.		Joann Ardill 20a. Mathod of Disposition 1⊠ Burial 2 □ Crems 4 □ Donation 5 □ Ott	ation 3 🗆		20b. State	Place of Dis cemetery, c	5 Sheridan sposition (Name of rematory or other place	09)	Date	20c. Location -	City or Town, S	Stete
artme ortan Injur		21. Signature of Funeral Se			Mo	. Vet	's Cemt @ 22. Nama and Addre		p ////9	Flints	tone, M	ID
Depa Impo any Ir		111	0 /	7.0		1	Merritt-Ad		ral Home	2		
		23e. Pert1. Enter the disea shock, or heart failure	se or com	litrations that	caused the des	ath. Do not a	404 Decatu	r St. Cur	nberland	1, Md. 2		roximate
Medical Kaminer	ner	Immediate Cause (Finel disease or condition resulting in death)		a. lunc	Due to	CER L (or as a cons	with Standard variables of: V	reletal o	and h	epatic	3	mos
d ansit	E	Sequentially list conditions		b. ———	Due to	for se a cons	equence of:					
physician and the bunal-transit	dical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated evants resulting in deeth) Last	{	b			sequence of):					
ending physician and r use as the bunal-transit	edical	triat initiated evants	{	c								
he attending physician and hed for use as the bunal-transit	edical	triat initiated evants	l		Due to (or as a cons	equance of):	en in Pert t.	23b. Did	tobacco use cor	ntribute to the	cause of dea
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State of Maryland / Department of Health and Mental Hygiene

						,	C	ertificate of	Death	R	eg. No.	5 2	1905
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	/Medi		Jeannett	te M. M	cHugh					June 25			10:30 a.m
	Examir		4a. Fecllity Name			ım <i>ber)</i>				or Location of Deeth	4c. County		
			Egle Nur		ne				Lonacor		Alle	gany	
	inerai rector		5. Social Security 220-07-6	069	Sex 1□M 2⊠F	7. Age (In ye	s. last birthda Yrs.	y) If Under 1 Year Months Days	Hours N	Irs. 8. Date of Birth (Month, Day, Septembe	Year) er 24,19	9. Birthpla Counti	ace (State or Foreign ry) MD
and	* \$		Usual Residence of 10a. Stete	10b. County		10c (City, Town or	1 ocation				10	d Incide City I Imite
faryla	aho ad at	5	MD	Allega	nv		onacon					10	d. Inside City Limits 1 Yes 2 No
the N	28a-	Director	10e. Street and Nu		i i y		Oriacori	0					
with	0 8							10f. Zip Coda		1	0g. Citizen of V	Vhat Countr	ry?
eath	8 23	era	9 Park P.	Lace	40 W D	-1		21539			USA		
72 hours efter death with the Maryland	"natural", or flems 23a or 28a-f ahow edical Examiner must be notified at	by Funeral	11. Maritei Stetus 1 ☐ Never Mar 3 ☐ Widowed	ried 2 Married	Armed Fr	25 No	U,S. 13	If Yes, specify Cut		(Specify Yes or No- erto Rican, etc.)	Blec	e - Americe k, White, et : Whit	tc.
72 hc	lical fical	Completed	(Sne	15. Decedent's	Education grade completed)		16a. Dec	edant's Usual Occu	pation	and in a	16b. Kind of Bu	sinass/Indu	ustry
.⊆	the Medical	npie	Elemantary/Sec		Coliaga (lifa	re kind of work done DO NOT use retire	duning most or (ad)				
filed with Hygiene.		So	12		2		Cler	k			Clothin	g sto	re
東京 三	event,	Be	17. Fether's Neme	(First, Middle, La	st)				18. Mother's N	lama (First, Middle, M	Maiden Sumam	Θ)	
should be	marked matic e	2	John I	Bradbu	m				Lydia	Martin			
	7 is marke traumatic		19a. Informant's N	ame/Relationship	(Type, Print)		19b. Ma	liing Addrass (Stree	t and Number or	Rural Route Number	City or Town,	State, Zip C	Code)
	er tr		Sara Schi	camm	sist	er	34 H	anekamp S	treet, 1	Lonaconing	, MD 21	.539	
6 0	or other		20a. Method of Dis		☐Removal from		Piaca of Disp cometery, cr	position (Name of ematory or other pla	ice)	Date	20c. Location -	City or Tow	m, State
Peges	ary of			5 Other (Spe		Fre	stburg	g Memoria	l Park	June 27 1998	rostbur	g, MD	,
permit. Peg Department	mportant: any injury pnce.		21. Signature of Fi					22. Name end Addre	ess of Fecility	1990			
28.	any		Jan	un EY	nckenz	cė		Eichhorn-	McKenzie	e Funeral	Home P.	Α.	
			23a. Part1. Enter	he disease, or co	mplications that	caused the de	ath. Do not e	8 E. Main	Street	Lonaconi liac or respiratory are	ng, MD	21539	Approximate
hvs	ician		shock, or has	irt failure. List on	ly one causa on a	aach line.				,			Approximate Interval Batween Onset and Death
	dical		Immediate Cause	(Final		(. ~/:		0/	11			260
Exar	niner		disease or condition resulting in death)	on	a	Cook	1/01/0	gen12	Snock	K two vsclensis			JAZ.
		ē				Due to	(or as a cons	equance or):	i f.	+.		- 4	76-
5 ,	ansi	Examiner	Secure tight list or	nditions	b	Due to	7004	concerns of	11/44	· Cas		-	3117.
בפונווויבפופ חפ פאפכחו	in en nial-tr		if eny, leading to in cause. Enter Under	nmadiate		00010	(Of as a const	squerice orj.	04/00	colones		1	oper
	pnysician end s the burial-transit	Medical	Sequantially list co if eny, leading to in cause. Enter Unde Cause (Diseasa or that initiated event	Injury	C	Due to	or as a conse	14/174	ajuero	13618/0315			-91.
	es th	8	resulting in death)	Last		Due to	OI as a COIIse	equenca oi).					
	attending pr				d								
Jae I	deteched for use	Physician/	Port II Other clerk	lland and the									
me deam	ochex	Jys.	A					underlying cause gi	ven in Part I.				the cause of death?
1	dete	P	A	dvance	den	ent 14	, No	11264		1 L Y	8 2 No	3 Proba	ably 4 Unknown
Ine law requires that	2 should be	Completed by						tive he	ert fulu	24a. Was ar perform		com	e autopsy findings lable prior to pietion of cause eath?
901	ebec	Ö		atric!	1.6	illost	in c	leep von	+homely	// 1□ Ya	s 2 000	10	Yes 2□ No
Attenuing Priyacians: Inc or deeth.	dor,	Be	25. Was case refer			10/00/		cc-y och		Death (Check only on	a)		
the op	direction of	2	examiner? 1 ☐ Yas 2 🔀	No	Hospital:	Inpatiant 2	☐ ER/Outpatio	ent 3 DOA Ot		Home 5 ☐ Raside		r (Specify)	
2	le la		27. Manner of Deat		28a. Date	of Injury th, Day Year)	28b. Time	of 28c. Inju		28d. Describe ho			
eth.	- de -	atio	2 Accident	5 Panding Investigati		iri, Day rear)	Injury		Yes 2 □ No				
the state	completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not detarmine	d 286. Piece	of Injury - At ng, etc. (Spec	home, ferm, s	treet, factory, office		28f. Location (St. City or Town	reet and Number, State)	er or Rurel I	Route Number,
within 24 hours	oletely fill	edical	29a. Certifier (Check only one)	Certifying F 2 Medical Ex	minar: On the ba	best of my kn asis of examin ner stated.	owledge, dea ation and/or i	th occurred at the tinnvestigation, in my o	me, date and pla oplnion, death oc	ca, and due to the ca curred et the time, da	use(s) and mai ite and place, a	nner as stat ind due to ti	ted. he ceuse(s)
To tr Within	Eoo	Σ	29b. Signeture and	title of certifier		-		29c. Licens			d. Date signed		
			/	1 km		40.6	2 m	2 1	211	80	6-	26-	98
3	1.	-	30. Name and addr	ess of nerson who	oompleted cause	a of death (It-	m 23a) /Turn	Print)	2140	88 as Auc, C			10
UL)		-	Lonas	T /	Deidi		D., 20	Donal	1. Au 1	nance	1	111
	Star	0	31. Date filed (Mon		32 R	egistrar's Sign	nature	V., 20	Dougl	41 100,0	o-cully	1791	100
	Sta		BELL O.	P 4000	ft. Be a	(A)	1		-				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year ORR DUNDAS SIMPSON JUNY 6:08 AM 1998 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death NURSING HOME LONACONING ALLEGANY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 10√M 2□ F H6-01-314 98 Yrs DEC. 18 1899 SCOTLAND Usual Rasidance of Dacedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD ALLEGANY 1 Yes 2 No LONACONING 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 57, ROBIN 21539 USH 11. Marital Status Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indian, Black, White, atc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 12 Pattern Maker Wood 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meldan Sumeme) Robert Orr Agnes Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 23911 McMullen Highway SW, Rawlings, MD 21557 Jean C. Mullen Niece 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition July 6, 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 1998 Cumberland, MD Cumberland Crematory 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD 21539 shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onset end Death Cell Carcinoma of mouth Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an eutopsy performed? the persons 25. Was case rafarred to medical 2 X No perlension 1 ☐ Yes 2 ☐ No examiner?

Physician /Medicai Examiner

physician and s the buriel-trans

been signed by the attending should be detached for use as

has

After this certificate

funeral director,

completaly

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

The law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760.

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

þ

10a. State

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svent, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Haalth and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic svent, the Medical Exercises once.

altimore, Maryland 21215-0020

death with the Marylend

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last

27. Mannar of Death

1 Natural

2 Accident 3 Suicide

4 Homicida

29a. Cartifier

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

MD

1 Certifying Phyaictan: To tha best of my knowledge, daath occurred at tha tima, date and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and mannar stated.

LONACONING

29c. License number

29d. Dete signed (Month, Day, Year)

21539

30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print) ST. 57 JACKSON

Hospital:

5 Pending investigation

6 Could not be daterminad

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)

28b. Time of

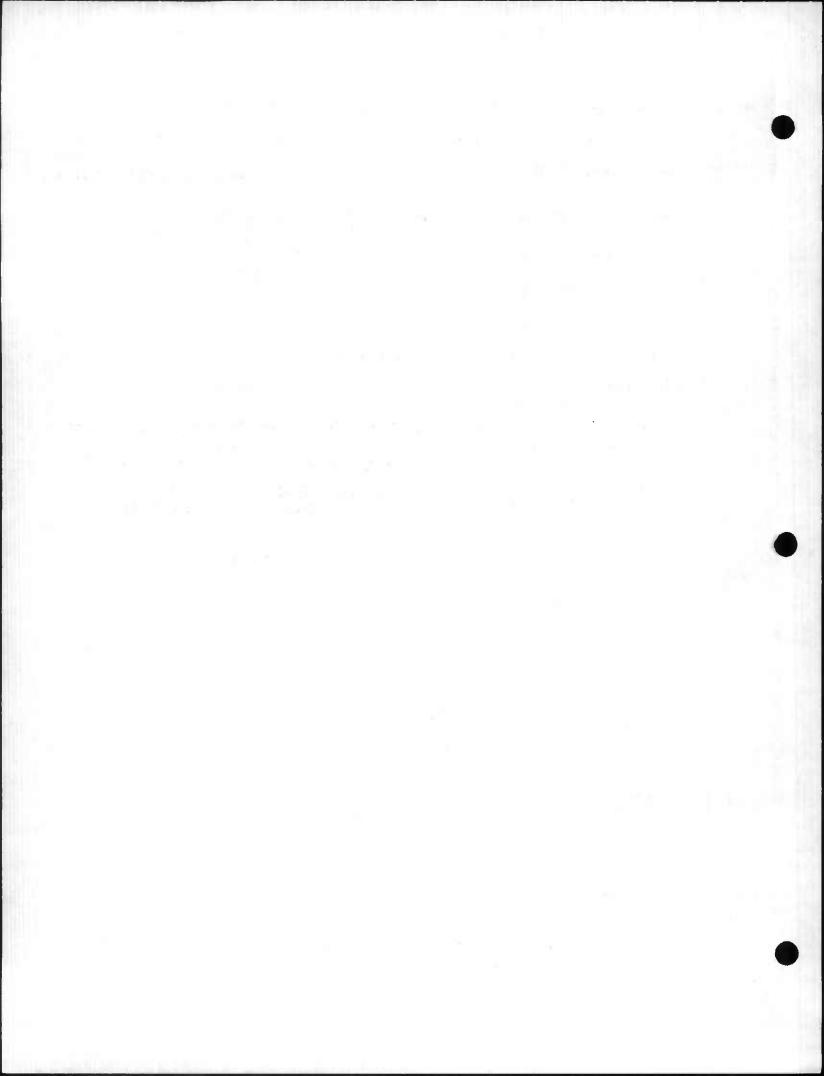
L.R. MILES, VR., M.D. 31. Date filed (Month, Dey, Year) 0 7 1998

29b. Signature end title of cartifier

82. Registrar's Signature

28a. Data of Injury (Month, Day Year)

NX. State Registrar



State of Maryland / Department of Health and Mental Hygiene

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						C	ertificate	or D	eatn		Reg. No.	- Ind	1001
	Physician	1	 Decedant's Nama (First, Middla, La CLARENCE ALONZA 		JR.					2. Data of De Month	Day	Yaar	3. Time of Death 1448
	/Medica Examine	-	4a Facility Nama (If not institution, given	a street and numb	er)			4b	. City, Town, or Lo	ocation of Deeth	4c. County	of Death	
	= 1		SACRED HEART	HOSPITA	L			C	UMBERLAN	D	ALL	EGANY	
	Funeral Director		213 10 0000	. V	Aga (In yrs. I	ast birthda Yrs.	y) If Undar 1 \ Months D	raar Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da MAY 22	y, Year)	9. Birthpla Country MARYLA	
and a	ž	1	Usual Rasidance of Dacedant 10e. Stete 10b. County		10c. City	, Town or	Location					100	I. Inside City Limits
Aaryl	of and	5	IARYLAND ALLEGAN	TV.		MT (TATA OT						1 □ Yas XXNo
the	or 28a-f a	5	IARYLAND ALLEGAN 10e. Streef and Number	1		MII.	SAVAGE 101. Zip Co	oda			10g. Citizen of	What Countr	17
W.	2 2	5	12701 NEW SCHOOL	ROAD. NW	. АРТ	2	215				U.S.		
death with the Maryland	22	2	11. Marital Status						penic Origin? (Sp , Maxican, Puarto	ecify Yes or No		ce - Amaricar	
d within 72 hours after d	ef, or items 23s or 28s-f show Examiner must be notified at the Eumanal Director	na Lau	1 □ Navar Marriad 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceda Armed Force 1 X Yas 2 If Yas, Give Yaar or Data	□ No WW	II	If Yas, specify 1 ☐ Yes 2 X			Rican, atc.)	Bla Specif	ck, Whita, at y: WH]	
2 hot	"naturel", edical Exp	2	15. Decedant's E	ducation		16a. De	cedent's Usual C	ocupat	ion	in-	16b. Kind of B	usiness/Indu	stry
within 7	ygiene. Ner than "natur ft, the Medical	2	(Specify only highest gra Elamantary/Secondary (0-12)	Collega (1-4	or 5+)	(Gi	DO NOT use r	ratired)	ring most of work	ing			
D Wil	giene.	Ş	8	Ounday (1 4	0.0.7	LA	BORER				RAIL	ROAD	
	marked other marked other marke event, t		17. Fathar's Nama (First, Middla, Last)					18. Mothar's Nam	a (First, Middla	, Maidan Sumer	ne)	
old b	Mental arked o attic eve	2	CLARENCE	ALONZA O	'NEAL,	SR.			SUSAN S	KIPPER			
2 sh	S		19a. Informant's Name/Ralationship (RONALD O'NEAL / S			75.00			nd Number of Run BUCKHAN			, State, Zip C	Code)
98	0	-	20a. Method of Disposition \$\int\text{XBuriel} 2 \subseteq Cremation 3 \subseteq 4 \subseteq Donation 5 \subseteq Othar (Speci		0	ematery, c	position (Nama rematory or otha	r place	ST CEM.	Data 7 / 6 / 0 9	20c. Location		
	Department important: important: in portant: in portant: in processing any injury of processing and injury of processing		21. Sonatura of Funaral Sarvica Lica 23a. Part1. Enter tha disaasa, or con shock, or heart failure. List only	plications that cau	h lina.	Do not	00 W. MA	UNE IN of dying	RAL HOME ST., FRO such as cardiac	STBURG, or respiratory a	rrast,	1	Approximate nterval Between Onset and Deeth
	Medical caminer		Immediata Causa (Finai disaasa or condition resulting in daath)	· CARO			OF La	&f	hunga	plea	val Eff	LUSION	3 Morvi
		5			200 10 (0	1 43 4 0011.	suquunoo ory.						
certificate be executed	ding physician and ise as the bunal-transit	Cyallin	Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Disease or in jury that initiated avants	b	Dua to (o	as a cons	sequance of):						
ficate be ex	physicials the bu	200	Ceuse (Diseese or injury that Initiated avants resulting in death) Last	C	Dua to (or	es e cons	equence of):						
certif	ding use as	2		d									
death	for u	6											
he de	signed by the atte	, A	Part II. Other significant conditions			0		sa give	n in Part I.		,		he causs of death?
that the	data data	2	ARTERIOSCIERO	TIE Hes	art L	1581	4SE			112	Yss 2∐No	3 Probe	ibly 4 🗆 Unknow
w requires	shoul	neted D	ARTERIOS ELERO ATRIAL FIB	21LCAT.	ion					24a. Was	an autopsy omed?	avai	a autopsy findings lable prior to pletion of cause seth?
Physician: The law requires the	a has	5								10	Yas 2 No		Yas 2□ No
E	certificata irector, pag		25. Was casa rafarrad to madicai						OR Disea of Deal			1	140 2010
Physician:	is certificata ha director, paga	ן פ	axaminar?	Hospital: 1 ☑ Inp	ationt 2	ER/Outpat	ient 3 DOA	Otha	26. Placa of Deal		idanca 8 🗆 Oti	her (Specific	
	E = '		27. Manner of Death	28e. Date of i	injury	28b. Time		Injury Work			how injury occu		
ding	After this funeral		1 ☑Natural 5 ☐ Panding	(Month,	Day Year)	Injur	M		? as 2□No				
ŏ.	ours after death. oral Director: After titlled in by the funeral	a mica	2 Accident 3 Suicide 6 Could not to datarmined	28e. Place of	injury - At ho , etc. (Specify	ma, farm,	straat, fectory, o				Streat and Num wn, Stata)	ber or Rural	Routa Number,
spitai		5	29a. Cartifier 1 Certifying Pl	nysician: To the be	ast of my know	wledge, de	eath occurred at 1	tha time	a, data and place,	and dua to tha	cause(s) and m	annar es sta	ted.

29c. Licansa number

30. Name and addrass of person who completed causa of daath (Item 23a) (Type, Print)

SATURNINA CHANG, M.D Rt 3 6 Frost Gung Plaza Frust Gung Maryland 21532

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signatura end fitte of cartifiar

A AMERICAN PROPERTY. AND THE RESERVE OF THE PROPERTY OF THE PROPERT

State of Maryland / Department of Health and Mental Hygiene 00

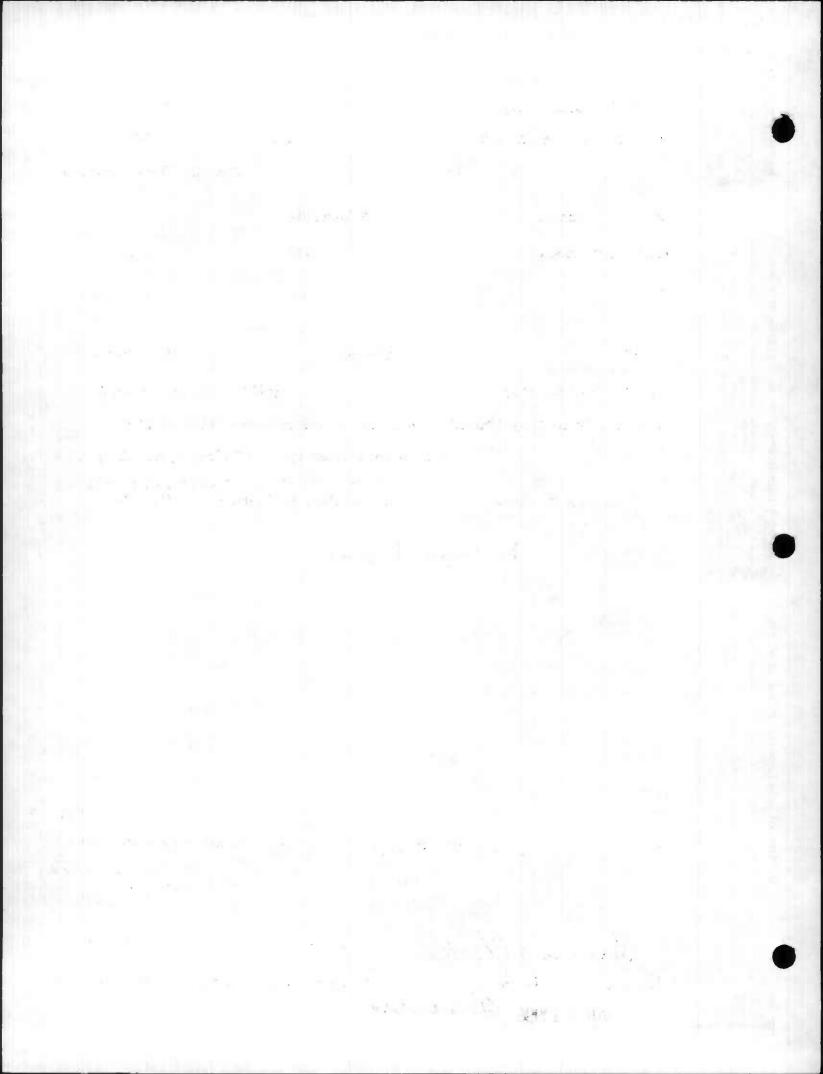
_			Certificate of Death		Reg. No.	21908
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Lillian Neathery Pierce	2. Dete of Dec June 2		3. Time of Death 5:45pm
þ	Exami		4e. Fecility Name (If not institution, give street and number) 2465 McHenry Drive 4b. City, Town, Mt. Air	or Location of Death Y	4c. County of Dee	ath
	Funeral Director		221 03 1000 ILIM 222F 02 Yrs.	Hrs. 8. Date of Bird fin. (Month, Da NOV 24	9. Bi 1915 NC	rthpiece (State or Foreign jountry)
	Meryland a-f show	ctor	Usuel Residence of Decedant 10e. Stete 10b. County 10c. City, Town or Location Odenton			10d. Inside City Limits 1 ☐ Yes 2 No
	3a or 28	i Director			10g. Citizan of Whet C USA	country?
020	d within 72 hours effer death with the Meryland jiene. I than "natural", or items 23s or 28s-4 show the Medical Examiner must be notified at	by Funeral	3 ¼ Widowed 4 □ Divorced If Yes, Give 1 1 □ Yes 2 ¼ No Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Rece - Am Bleck, Wh Specify: Wh	ite, etc.
215-0	nin 72 ho n "natur	Completed	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Business	s/Industry
21	73 75 4	Com	Elamantary/Secondery (0-12) College (1-4or 5+) Sales manager		Read's dru	gstores
land	2 2 2	To Be	Joseph Lee	Nama (<i>First, Middl</i> a, DWN	Maiden Sumame)	
, Maryland 21215-0020	CENL		19a. Informant's Neme/Ralationship (Type, Print) Howard Neathery (son) 19b. Malling Addrass (Street and Number of 2630 Summer Breeze Commer Breeze Breeze Commer Breeze B	Rural Routa Numbert. Odento	or, City or Town, State, n, MD 2111	Zip Code)
Baltimore,	ages ant of t: If it		20a. Method of Disposition 1 Burial 2 To Cremation 3 Removel from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, cramatory or other place) Carroll Cremation Serv.	Deta 6-29-98	20c. Location - City o Hampstead,	
Balt	permit. Pa Departmen important: any injury once.		21. Signetury: Funeral Servica Licansee 22. Name and Address of Fecility P.O. Box 195 Syke	Haight Fu	neral Home d. 21784	& Chapel
	Dhusisian		23a. Part1. Enter the diseasa, or complications that baused the death. Do not anter tha mode of dying, such as car shock, or heart failura. List only one causa on each line.	diac or respiretory a	rest,	Approximate Interval Between Onset end Deeth
	Physician /Medical Examiner		Immediate Causa (Final disease or condition resulting in death) a. Metastanc CholargioCar	cinana		Month
	7 4	Je .	Dua to (or as a consequance of):			
68760,	rificate be executed ng physician and as the bunal-transit	edicai Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disaase or injury that initiated avants resulting in deeth) Lest Due to (or as a consequence of): Due to (or es a consequence of):			
. Box	eath ce ettendii for use	Physiclan/Medicai	d. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23h Didi	ohacco use contribut	e to the cause of death?
. P.O.	that the de led by the detached		NON INSULIN DIABERES MELLITUS	1 🗆	Y	Probably 4 Unknown
Records,	law requires that the es been signed by the 2 should be detache	Completed by			an autopsy 24b.	Were eutopsy findings available prior to completion of cause of death?
= Re	The ate h	Comp		101	es 2 No	1 ☐ Yes 2 No
VITE	Physiclan: this certific ral director,	To Be	axaminer? Uther:	Death (Check only o		
on of	는 는 현		27. Mannar of Death 1 Anatural 5 Pending 28a. Data of Injury 28b. Time of Injury 28c. Injury at Work?	-	denca 8 Other (Sp. now Injury occurred	эспу)
Division of Vital	or Atten after deal Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be datermined 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify)	28f. Location (S City or Tox	Streat and Number or F m, Stata)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end placed in the composition of the compositi	lace, end due to the ceuse(s) end mannar as stated. occurred at the time, date end pleca, and dua to tha causa(s)		
V	To th withir To th comp	Me	29b. Signeture and title of cartifier Columnia mo 29c. License number D31660		29d. Date signed (Mor	
			30. Name and eddrass of person who complated causa of death (Itam 23a) (Type, Print) THOMAS CAIVE MD 295 STONEL AVE	WESM	m nega.	۵ کاالی
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 1 1998			

DHMH 16 Rev 6/95

not to a great

JILL PEAY ASP		State of Maryland	/ Department of Certificate of	Health and I	Mental Hygi	ene 9	3 2190	9
Physician /Medica Examine	JIII Marie	Peay street end number)		4b. City, Town, or I	2. Dete of Deeth Month JUNE Location of Death	Day 26 1 4c. County		
Funeral Director	5. Social Security Number 214–15–4072 Usuel Residence of Decedent	7. Age (In yrs. las	Yrs. If Under 1 Yes Months Day		8. Date of Birth (Month, Day July 25	1982, 1982	9. Birthplace (State or Country) Maryland	Foreign
he Merylend Sa-f ahow ordred at	MD 10b. County Carroll	,	Town or Location Sykes				10d. fnside City 1 ☑ Yas	
ath with ti	10e. Street and Number 7429 Norris Avenu		10f. Zip Code	21784			S.A.	
Maryland 21215-0020 d 2 should be filed within 72 hours effer death with the Merylend th and Mentel Hygiene. T le marked other than "natural", or items 23a or 28a-f show traumetic avant, the Medical Examiner must be notified a		12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No tf Yes, Give Yeer or Detes:	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (S lben, Mexican, Puert o Specify:	pecify Yes or No- o Rican, etc.)		- American Indien, k, White, etc. - White	
Maryland 21215-0020 d 2 should be filed within 72 hours of th and Mentel Hygiene. 7 le marked other than "natural", or traumetic avant, tra Medical Exam	15. Decedent's Edu (Specify only highest gred 15. Decedent's Edu (Sp		16a. Decedent's Usuai Occ (Give kInd of work don life. DO NOT use reti Student	upation le during most of wor red)	rking	eb. Kind of Bu	siness/industry	
and be file avant.	17. Father's Name (First, Middle, Last)				me (First, Middle, M			
2 should be and Mentel and Mentel and Mentel and Mentel and Mentel and marked or authorities.	James Daniel 19e. Informent's Name/Relationship (Ty	Peay pe, Print)	19b. Mailing Address (Stre		hia Cath ural Route Number,			
P on Al A	Mr. & Mrs. James H			Avenue Sy				
Pege ment o ant: If I	20a. Method of Disposition 1X Burial 2 Cremetion 3 R 4 Donation 5 Other (Specify)	emoval from State Spr	ce of Disposition (Neme of netery, cremetory or other pringfield Cem	etery	6/29/98	Sykesv:	ille, MD	
Baltim permit. Pe Department: Important: any Injury	21. Signeture of Funeral Service License Buan 23a. Part1. Enter the disease, or complishock, or heart feilure. List only or	Hay 1-2	Sykesvil	UNERAL HOLE, MD 21 ying, such as cerdiac	784 (410)	-795-1		
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	Multiple	Injuries is a consequence of):				Onset and Do	eath
death certificate be executed the ettending physician and of for use as the bunel-transit	Cause (Disease or Injury thet initieted events	·,	s a consequence of):					
P.O. hat the hat the detache	Part ti. Other eignificant conditions con	tributing to death but not resulti	ng in the underlying ceuse	given in Part I.		s 25No	tributa to the cause of	
w requir					24a. Was an		24b. Were autopsy fin aveilable prior to completion of ce of deeth?	
					1 ⊘ ¥e		1 /8 ves 2□ N	10
hysician hysician his certifi director		lospitel: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3□ DOA	Whor	ath (Check only one		er (Specity) ROADV	AIA V
O		28a. Date of Injury (Month, Dey Year)	8b. Time of 28c. In		28d. Describe ho	w injury occurr		MAY T
DIVISION (tal or Attanding P is efter death. al Director: After t led in by the funera	3 Suicide 6 Could not be determined	28e. Plece of Injury - At hom building, etc. (Specify)		9	28f. Location (Str. City or Town,	State) 6000	er or Rural Route Numb Blk Poncee A	er,
he Hospl in 24 hou he Funer pletely fil	29e. Certifier 1 Certifying Physical Check only 2 Medical Examination	eleten: To the best of my knowle her: On the basis of exemination						
To the Hospital or a within 24 hours after To the Funeral Dire completely filled in b	29b. Signature applittle of certifier	I Chuts 10	29c. Lice O.C.	nse number M.E			(Month, Dey, Year) 6,1998	
	30. Name and address of person who complete the state of	noveted ceuse of deeth (Item 2 h w (m))	111 Per	n Street,	Baltimo	re, Mar	yland 2120	1

State Registrar JUL 0 1 1998 32. Begistra a Signature



Physician /Medical **Examiner**

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Haalth and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventhel must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

NIS PERRY '	icase i		Marylan	d/D		nent o	f H	ealth a		_	Hygi	ene	98		210	910
Decedent's Name (First, II	Middle, Last)				<i>3011111</i>	care c	01 1	Catri		2. Dete		g. No.			3. Tima	of Death
RICKY		DENN	IIS		P	ERRY				Monti JUI		Day 01	Yea 1998		131	13 P
4a Facility Name (If not Insti CIVISTA HO	itution, give SPITA		nber)				4	LAPL	ATA	ocation of	Death		ARLES			
5. Social Security Number 219-54-8446	6. Ser	M 2 F	7. Age (In yrs. 1			Under 1 You	ear ays	If Under Hours	24 Hrs. Min.	8. Date (Mont	of Birth h, Dey, ST 2	Year) 23,19	9.6	lirthplac	Stete VSYL	or Foreign VANIA
Usuei Residence of Deceder 10e. Stete 10b. Co			10c. City	v. Town	or Locatio	n								10d	inside	City Limits
MARYLAND	170	RLES			ALDO											s 2 No
10e. Street end Number	011111			-		of. Zlp Cod	de				10	g. Citize	n of What	Country	7	
3551 SNOWBE	LL CO	JRT				2	206	02				U	.S.A.			
11. Maritai Stetus 1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ Divo	dent Ever in U, ces? 2 [X] No e tes:	S.	If Yes	Decedent s, specify (Cube	spanic Ori n, Mexicar Specify:	gin? (S) i, Puerti	pecify Yes o Ricen, etc	or No-		14. Race - American Indien, Black, White, etc. Specify: White					
	edent's Edu			16a. [Decedent's	Usual Oc	ccupa	ition	4 04	trina	1	6b. Kind	of Busines			
(Specify only h Elementary/Secondary (0-		College (1-	4or 5+)		iifa. DO N	TILE	etired	oNTRA				SE	LF EM	PLO	YED	
17. Father's Nama (First, Mic						18. Mothe	er's Nan	ne (First, M	iddle, M	aiden St	umame)					
WILLIAM B.						MAR:	IE S	EBRIN	IG							
WANDA H. PERR								Waldo								
20a. Method of Disposition 1 ☐ Buriel 2 ☐ Creme 4 ☐ Donation 5 ☐ Oth		emovel from S			Disposition cremetor MEM	y or other	r plec		NS U	Date JULY 6			WALDC			RYLAND
21. Signature of Furnarial Ser	1.13	icha	00053			HUN	TT		RAL	HOME DORF,			ID 20	0604		
23a. Part1. Enter the diseas shock, or heert failure.	BROHAV sa, or compli List only or	cations that ca	used the death	n. Do no	ot antar th									A Ir	oproxim nterval B nset en	letween
Immediate Cause (Final disease or condition resulting In death)	a		There Dua to (o		ensequand		Ca	erdi	ove	asau	las	2) is e	us.		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury			Due to (o	rasaco	onsequenc	ca of):										
that Initiated events resulting in death) Last	1		Due to (or	r as a co	onsequenc	e of):					,					
														ì		
Part II. Other significant cor	nditions con	tributing to de	ath but not resi	ulting in	the under	ying caus	e giv	en in Part		23b		acco us		Probe		of death?
										24a.	Was ar	autopsy ed?	y 24	com	able prio pletion o	y findings or to of ceuse
											y Ya	s 20	No	of de		□ No
25. Was case referred to me axaminar?		lospitai:					Oth	O.F.		ath (Chack						-
1 ∑ Yes 2 No		111		ER/Outp	-	X DOA	Oth	4 LI NI	ırsing H	lome 5				pecity)		
	ending vastigation	28a. Date o (Monti	n, Dey Year)	ar) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred Work?												
2 Accident invastigation 3 Suicide 6 Could not be detarmined 28e. Placa of Injury - At h building, etc. (Spacial Country - At h building, etc.)											tion (Str or Town		Number or	Rural I	Route No	ımber,
29a. Cartifiar 1☐ Cor	tifying Phys	Iclan: To the I	pest of my know	wledge,	death occ	urrad at th	ne tin	e, data ar	d piace	, and dua t	o the ca	use(s) a	nd mannar	as stat	ed.	

To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

one) On the basis of exa and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E

02,1998 JULY

31. Date filed (Month, Dey, Year)

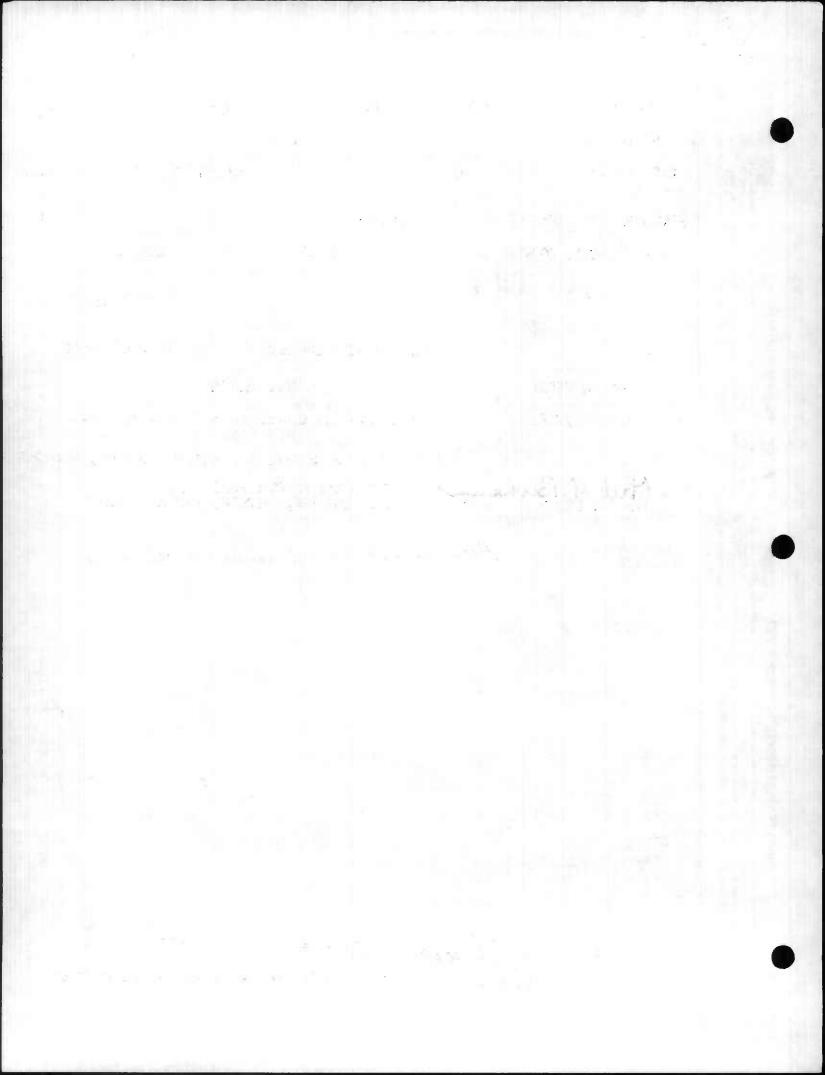
30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar's Signature JUL 0 7 1998

ste mo

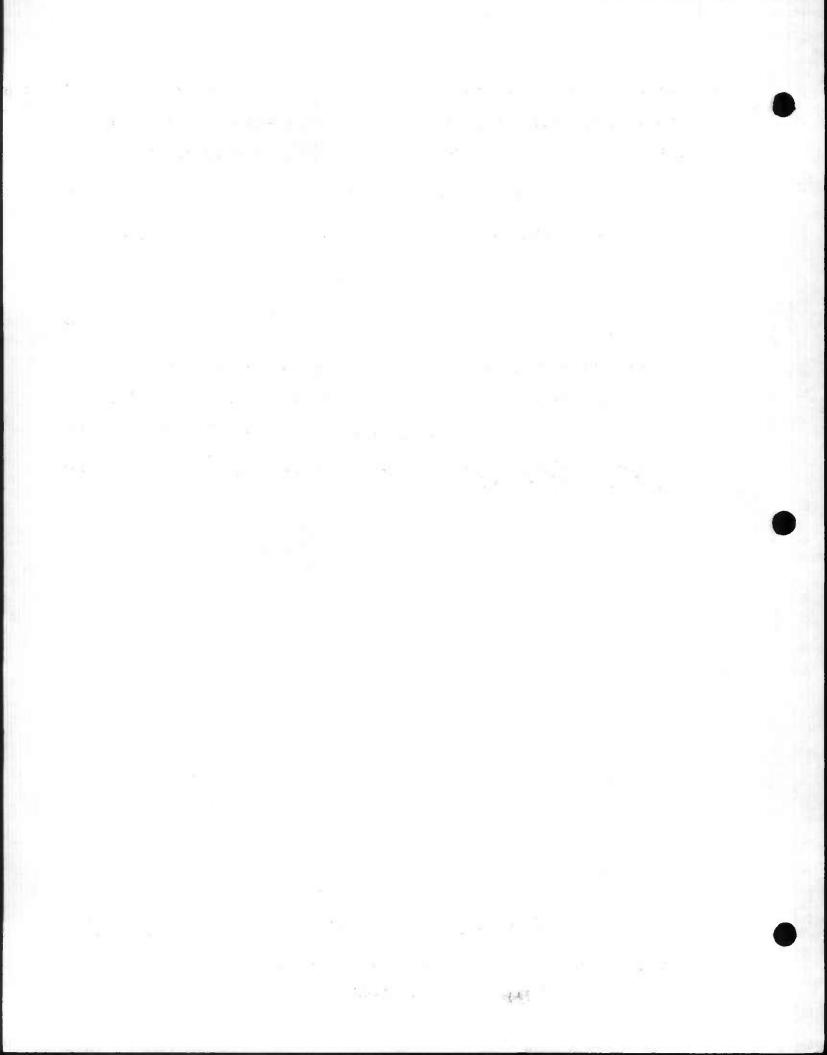


State of Maryland / Department of Health and Mental Hygiene

				Ť	Certificate of	f Death		Reg. No.	0 6	1911
	Dhusia	i	Decedent's Neme (First, Middle, Last)				2. Date of Do		Yeer 3.	. Time of Death
4	Physic /Medi		Paul Demous Pier	ce			July			04:25
	Exami	ner	4e. Fecility Name (If not institution, give street end number			4b. City, Town, or				am
L			Calvert Memorial Hosp		at birthday) If Under 1 Yee	Prince	Freder	ick	Calver	
	Funeral Director		5. Social Security Number 249 58 4211 Usuel Residence of Decedent	ge (In yrs. las 59	Yrs. Months Dey			8, 193	9. Birthplace Country) 8 SC	(State or Foreign
	fand tand		10e. Stete 10b. County	10c. City,	Town or Location				10d.	Inside City Limita
	Manylan H ahow	to	MD Calvert	No	rth Beach					1 ☑Yes 2 ☐ No
	r 28s	irec	10e. Street end Number		10f. Zip Code			10g. Citizen of V	What Country?	
	th wit	ai D	9120 Chesapeake Ave.		207	14		U	SA	
020	n 72 hours after death with the Maryland "natural", or frems 28a or 28a-4 show refical Examiner must be notined at	by Funeral Director	11. Maritel Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Wes Deceden Armed Forces 1 □ Yes 2 ☑ If Yes Give Year or Dates	?	13. Was Decedent of If Yes, specify Cu		Specify Yes or Noto Rican, etc.)	o- 14. Rac Blac Specify	e - American li ck, White, etc. whi	ndien, ite
5-0	72 ho natur	P S	15. Decedant's Education (Specify only highest grede completed)		16a. Decedant's Usuel Occ	upation	dia	16b. Kind of B	usiness/Industr	ry
21215-0020		Completed	Elamantary/Secondary (0-12) College (1-4or	5+)	(Give kind of work don lifa. DO NOT usa reti truck dri	e during most or wo ed) Ver	rxing	cons	tructi	Lon
P	be filed that Hygie d other event, u	Be	17. Father's Name (First, Middle, Last)			18. Mother'a Name (First, Middle, Meiden Sumame)				
yla	should the marked umatic	2	Charles Valentine Pie					Reynold		
, Maryland	1 and 2 sh Health and am 27 is m		19a. Informent's Name/Relationship (<i>Type, Print</i>) Linda L. Pierce/wife		19b. Mailing Address (Stree PO Box	et end Number or R 1311, No				
Baltimore	of of		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)		ce of Disposition (Neme of netery cremetory or other pully Cemeter)	lace).	7-6-98	20c. Location - Bars	City or Town, tow, N	
3alti	permit. Pag Department Important: I any Injury o		21. Signature of Funantal Service Licensee	1	22. Neme end Add		Outpas	20726		
_	00540		11. 11/ded 14	20		Funeral	_	20736		
	Physiclan		Sa. Pert1. Enter the disease, or complications thet perse shock, or heert fallure. List only one cause of each	d the deeth. line.	/	`			Inte	proximete ervel Between set end Deeth
	/Medical Examiner		Immediate Ceusa (Final disease or condition rasulting in death)	Dua to (or a	EPE LU is a consequence of):	ves Ca	rein	and	3	; weeks
	p &	Examiner								
	and Hrans	хаш	Sequentially list conditions,	Due to (or e	s e consequance of):					
68760,	death certificate be executed eatending physician and ad for use as the burial-transit	aiE	Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events							
687	licate phys s the	edicai	resulting in death) Last	Due to (or e	s e consequence of):				i	
Box	nding use a	Σ	d							
m	death a atte d for	icia	Part II. Other significant conditions contributing to death	but not resulti	ng in the underlying cause of	viven in Part I	23b Did	tobacco usa co	ntribute to the	cause of death
0	es that the death cert igned by the attendin be detached for use	Physician/	CODD TRACT	R D	T. La 21	given in reiti.		Yes 2 No		y 4 Unknow
S, P	s tha	by F	COPI, Tovaces	thuse	2, t70Ha	<i>buse</i>				, , , , , , , , , , , , , , , , , , , ,
Records,	requir been s	Completed	Coronary Artery Di	sease	= PVD			en eutopsy ormed?	avaliab	autopsy findings ble prior to etion of cause th?
	The ate h	Com	Rotator Cuff tear H	'erm'a	topdesc	disease	_ 10	Yes 2 No		es 2 No
Vite	ician: The cartificate rector, pag	Be	25. Wes case raferred to medical examiner? Hospital:				ath (Check only	ona)		
of Vital	Physician: rthis cartific	. To	1 Les 2 Les 140		VOULDBILLIENT 3LL DOA		T	idenca 6 Oth		
O	After After funer	tion	1 Natural 5 Pending (Month, D	y Year)	Injury W	ork? □Yes 2□No	200. Describe	now injury occur	90	
Division	or Attending efter death. Director: After i in by the fune	Certification:	3 Suicida 6 Could not be determined 28e. Place of Ir		e, farm, street, fectory, office		28f. Location	(Street and Numb wn, State)	er or Rural Ro	ute Number,
ō	ital or A	Cer		tc. (Specify)						
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	edlcai	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and mennar s	of examination	edga, deeth occurred et the n and/or investigation, in my	time, date and plece opinion, death occu	e, end due to tha urred at the time	ceuse(s) end ma date end place,	inner as stated and due to the	t. ceuse(s)
	within To the	Me	29b. Signature and title of certifier		29c. Lice	nse number		29d. Dete signe	d (Month, Day,	, Year)
			I felper full		_ D	50563		07/	02/	98
	(-		30. Name and address of person who completed cause of	daath (Itam 2	3a) (Type, Print)					
	Ų.		Fulton Lukban, M.D.	Prin	ce Frederi	ck, MD	20678			

State Registrar

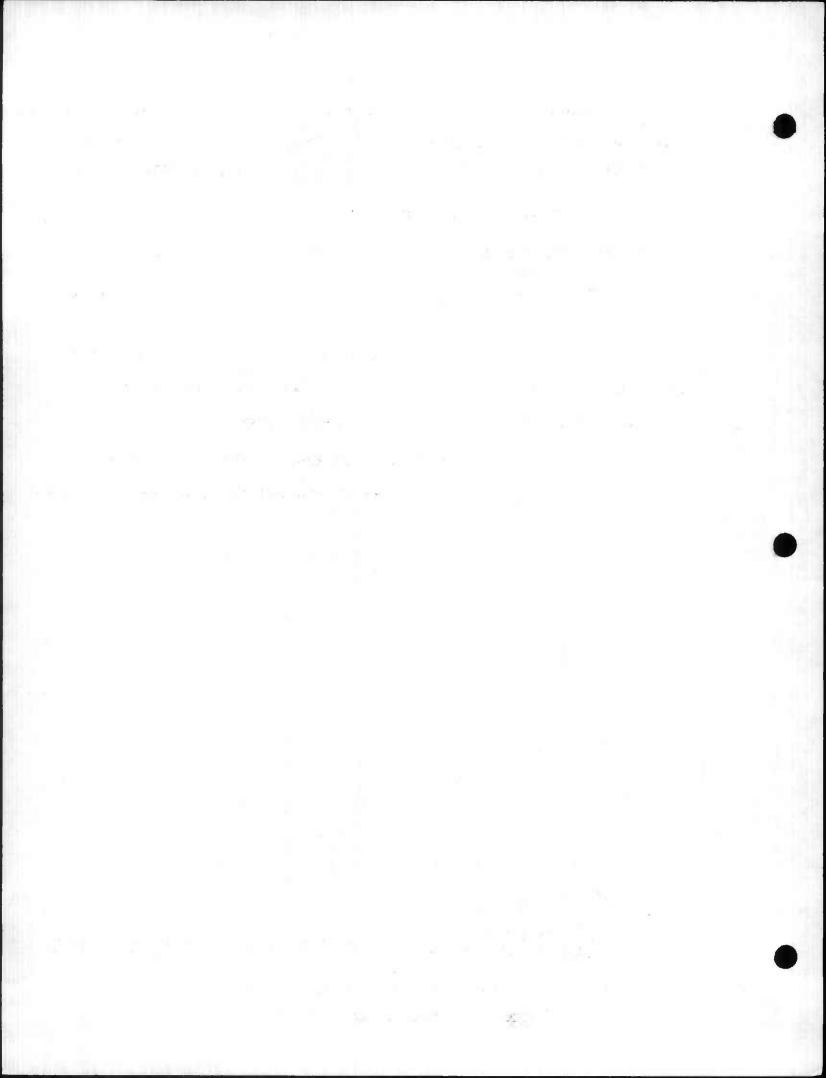
JUL 07 1998 > Julia allumbles Randals 31. Date filed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene

						Cert	ificate of	Death		Reg. No.	20	61:	112	
	Discorted		1, Decedent's Name (First, Middle, Last)						2, Date of D Month	eeth	Voor	3. Time of Death		
Physic /Med			Rober	t Irvi	ng		Perry		July	1, 19		12:	30 am	
	Examir		4e. Fecility Neme (If not institution, gi	ive street end number)					or Location of Dea		nty of Death			
			106 Valley V		Lane				Landing	,	ne Aru	ındel		
١	Funeral Director	To Be Completed by Funeral Director	212 34 5613		(In yrs. lest bi	Yrs.	Months Days	Hours M	in. Jan. I	irth Ay, Yess) 936	9. Birth	place (State intry) MD	e or Foreign	
aryland	anyland show dat		Usual Residence of Decadent 10a. State 10b. County MD Anne Ar	10c. City, Tov Tracy	vn or Loca	atlon anding						10d. Inside City Limits		
	he M									1 □ Yes 名型 No				
	23a or 2		10e. Street and Number 106 Valley Vi	ie		10f. Zip Code 207	779	10g. Citizen of What Country? USA						
	n 72 hours stier death with the Marylan "natural", or items 23a or 28af show edical Exarriner must be notified at		11. Meritel Status 1 Never Married 21 Married 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 ☒ Yes 2 ☐ N If Yes, Give Year or Detes:	Armed Forces? If Yes, specify Cuban, Mexican, Puèrto Rican, ☑Yes, Give 1050 60 1□ Yes, 2☑No Specify:				(Specify Yes or N erto Rican, etc.)	Spec	lace - Amari lieck, White cify: W			
	in 72 h		15. Decedent's E (Specify only highest gi	168	(Give ki	nt's Usual Occup	during most of v	vorking	16b. Kind of Business/Industry					
			Eiementary/Secondery (0-12)	Coilege (1-4or 5-	+)	life. Do	O NOT use retire	d)						
	T		12 17. Father's Name (First, Middle, Las		Fle	ctrician	1	lama /Fires Adielel		iction	Ĺ			
	od ita o		Robert Allen Pe				Lula		ne (First, Middle, Melden Surneme) Jeannette Tucker					
	should b ind Menta imerked		19e. Informant's Neme/Relationship	19	h Maillna	Address (Street			Route Number, City or Town, State, Zip Code)					
			Lorraine Perry/					as 10 ab						
	Item other		20a. Method of Disposition		20b. Piace o	of Disposi	tion (Neme of story or other ple	ce)	Dete	20c. Location - City of		own, Stete		
	Page nent chart: H		1 Donation 5 Other (Special Control of the S			James Parish Cen			7-3-98	Lothi	ian, M	, MD		
	permit. Pages 1 and 2 Department of Heelth s important: If Item 27 is any Injury or other tra once.		21. Signature of Funeral Servica Lice			Name and Addre		1 Home,	, Owings, Md 2073					
	_		23a. Part1. Enter the disease, or compile about that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate											
а	Physician		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death											
	/Medical		immediate Cause (Final disease or condition	Matak	statio	· [Lidne	y Sa	WCOM	a 2			noth o	
в	Examiner		resulting in death)	Due to (or as a			1 3.0	~			070.112			
	D #	iner	_											
	deeth certificate be executed to attending physician and ed for use es the burlal-transit	n/Medical Examiner	Sequentially list conditions,	0	Due to (or as a	as a consequence of):								
68760,	be ex		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C										
	phys s the		that initiated events resulting in death) Last	C	oue to (or es e	conseque	enca of):				1			
Box (certifice Iding ph													
	d for	Physician/	Part il. Other algnificant conditions	22h Die	23b. Did tobacco use contributs to the cause of death?									
P.O.	t the c	hys	at ii. Odioi eigiintent oottuttone	contributing to death bu	(not resulting	III GIO OIIC	renying cause gi	veri in rait i.		1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown				
ivision of Vital Records,	s that gned b	by P		-										
	law requires that the deeth ce as been signed by the attendi 2 should be deteched for use	Medical Certification: To Be Completed							24a. Wa per	s an autopsy formed?	8	Vere sutops vallable pric ompletion of death?	or to	
	B - B								10	Yes 20 No	1	☐Yes 2	□ No	
	ysician: The		25. Was case referred to medical examiner?	Death (Check only	eath (Check only one)									
	Q 00		1 Yes 2 No	Home 5-2 Res	Home 5-2 Residence 6 □Other (Specify)									
	fter thi		27. Manurer of Death 1 ☑ Netural 5 ☐ Pending	28a. Date of injury (Month, Dey		Time of Injury	28c. Injui Wo	ry at rk?	28d. Describe	28d. Describe how Injury occurred				
	To the Hospital or Attending is within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune		2 Accident investigation 3 Sulcide 6 Could not to				Yes 2 □ No		206 Leastion (Street and Mumber or Dural Doute Mumber					
	or At effer Direct In by		4 ☐ Homicide determined	ry - At home, fo (Specify)	erm, stree	et, factory, office		on (Street and Number or Rural Route Number, r Town, Stete)						
	phrai ours erai filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To the Hospital of within 24 hours of To the Funeral D completely filled I		(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) and manner stated.										3(s)	
	withir To th		29b. Signature and title of certifier	201		29c. Licens			29d. Date signed (Month, Day, Year)					
			· ru) Cle			D 1	6351	+	July	lst	199	8	
. ^	,	Ī	30. Name and eddress of person who	completed cause of de	ath (Item 23a)	(Type, P	rint)			J				
0	LIVA		Enser Cole, M.D			e Ro	ad, Anna	apolis,	MD					
	Sta	_	31. Date filed (Month, Day, Year)	2 1998 \ Ju	s Signature	. 6	2 0 00							
	Registr	ar	JUL U	W DEEL O	wa diaves	Menta	andrall							

DHMH 16 Rev 6/95



98-3694-009 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene NORMAN PAGE Certificate of Death PARRAN 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** NORMAN PAGE PARRAN, Sr. JUNE 28, 1998 00:05 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner ROUTE 4 AND FOWLER ROAD Dunkirk CALVERT Hours Min. Sept. 16,1934 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 215-34-3193 Yrs. Maryland Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Medical Examinal must be notified at 1 Tes 2 No Maryland Calvert Huntingtown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3355 Bayside Road 20639 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. nit. Peges 1 end 2 should be filed within 72 hours after serment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or the injury or other traumate avent, the Medical Emminent injury or other traumate avent, the Medical Emminent. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black Maryland 21215-0020 by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bricklayer Masonry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Wilson Elmer Parran Laura Harrod 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Norman P. Parran, Jr./Son 410 North Lane Prince Frederick, MD 20678 altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Pege Department of Important: If any injury or pace. Ernestine Jones Cemetery 7/2/98 Chesapeake Beach, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licansee 22, Name end Address of Facility Sewell Funeral Home Dladye a. 1451 Dares Beach Rd. Prince Frederick, MD 20678 serve 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Due to (or es e consequence of): 80 USB jo signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 8 24b. Were autopsy findings available prior to Completed 24a. Was en eutopsy performed? completion of cause of deeth? page 2 s has 1 Yes 2 □ No 1 XYes 2□ No certificate funeral director. Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) Certification: 27. Manner of Deeth 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 0005 M 1 Neturel 5 Pending Diver in cellison 6.28.98 1 ☐ Yes 2 0 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town State)

Box 68760 Division of Vital Records, or Attending Physician: after death. Director: Aft 24 hours a Hospital To the To the I

> State Registrar

filled in by

Medical

4 Homicide

(Check only one)

nd title of certifier

29a. Certifier

29b. Signature

30. Name and auditess of person who completed cause of death (Item 23a) (Type, Print)

Piece of Injury - Af home, farm, sfreet, factory, office building, etc. (Specify)

Ther

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s)

29c. License number

OCME

4 - fowler R

cause(s) and menner as stated.

29d. Date algned (Month, Day, Year)

JUNE 28, 1998

111 Penn Street, Baltimore, Maryland 21201

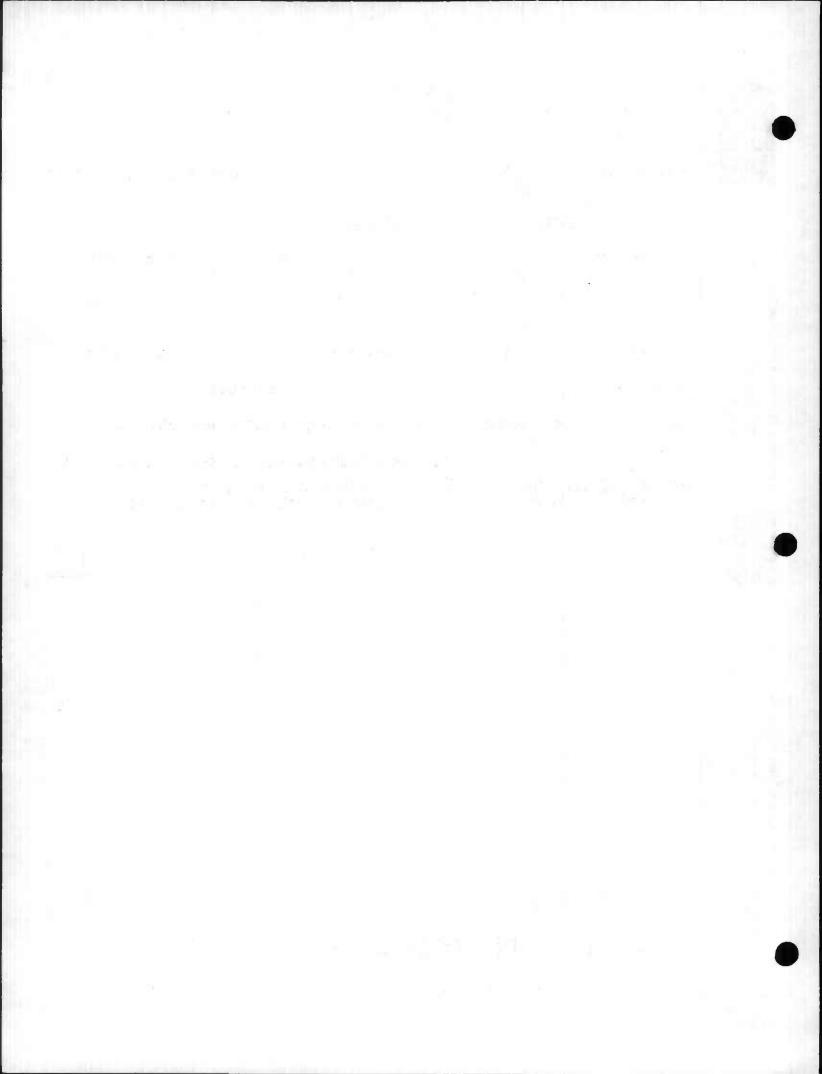
32. Registrar's Signature Julia Davidson Randall

end manner stated.

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U.S. I. Santi.

					State	of Maryla				Death	and ivie		giene Reg. No.	98	21	914	
	Physic	ian	1. Decedent's Name	(First, Middle, L	est)						2	2. Date of De Month	eth Day	Year	3. Tir	me of Death	
	/Medi		ANNONA JEAN REXRODE								JULY			998	8	:10PM	
	Exami	ner	4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth CHARLES														
	Funerai		5. Social Security N		Sex 1□ M 2 F	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours Months Days Hours Months					24 Hrs. 8	Date of Bir (Month, Da	of Birth h, Day, Year) 9. Birthplace (State or Fo			ate or Foreign	
	Director		Usual Residence of	93	TOW ZEET	75 Yrs.					N	OVEMBI	ER 12,	R 12, 1922 WÉS			
	Mend Mend		10a. State	10b. County		10c. C	ity, Town or Lo	cation						1	10d. Insi	de City Limits	
	Man	tor	MARYLAND CHARLES WALDORF												1 🗆	Yes 2K No	
	or 28	Directo	10e. Street end Nun	nber				10f. Z	ip Code				10g. Citizen of	What Cour	ntry?		
	23a		2531 RYCE	DRIVE		20601						UNITE	D STA	TES			
21215-0020	n 72 hours after death with the Maryland "natural", or frems 23s or 28s-f show sdical Examiner must be notified at	To Be Completed by Funeral	11. Maritel Status 1 Never Marrid 3 Widowed	ed 2 Married	Armed F 1 Tes If Yes, G	. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 13. Was Deceder If Yes, specify 1 ☐ Yes 2 ♥ 1 ☐ Yes 2 ♥				ent of Hispenic Origin? (Specify Yes or Nify Cuban, Mexican, Puerto Rican, etc.) Two Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE				
	72 ho		(Spec	15. Decedent's E	ducation	cation 16a. De			Decedent's Usual Occupation				16b. Kind of	of Business/Industry			
	within one. than		(Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) 12 (Giva kind of work done during molifie. DO NOT use retired) SECRETARY							d)	GOVERNMENT						
g	F P		17. Fathar's Name (First, Middle, Las	1)			18. Mother's Nan			First, Middle,						
e, Maryla			RALPH LAN	DIS						1	UNAVA	AVAILABLE					
	and and		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mailir	ng Addre	ss (Street	and Number	or Or Rural F	tural Route Number, City or Town, State, Zip Coda)					
	5 % 60 5		THOMAS E.		- SPOU		2531 Place of Dispo			VE, W			RYLAND				
	Peges 1 and of Her nt: If Item iry or othe			Cremation 3 l		State	cametery, crar	natory or	other pla			Date	20c. Location - City or Town, State				
	it. Perturbit		4 □ Donation 21. Signature of Full	5 Other (Spec		MI	HEBRO					, 1998	B, WINC	HESTE	R, V	Α	
Ba	permit. Peges Depertment of F important: if Ite any injury or of		MGR / O	G. BROH	349K	00053	THI	E HUI	TT F	SS of Facility FUNERA WALL	L HOM			0604			
			23a. Part 1. Enter the shock, or hear	e diseasa, or cor t failure. List only	plications that one cause on	caused tha deceach ilne.	ath. Do not ent	er the mo	de of dyl	ng, such as o	cardiac or r	raspiratory a	rrast,	1		I Between	
	Physician /Medical		Immediate Causa (Einel	OTT 2	Onset and Deat									and Death		
	Examiner	Н	disease or condition resulting in death)		a	CHRONIC OBSTRUCTIVE PULMONARY							Y DISEASE 93				
		Examiner			Due to (or as a consequence of):												
	eeth certificete be executed attending physician and for use as the burial-transit		Sequentiatly list con	editlone	b. — Due to (or as a consaquance of):												
Division of Vital Records, P.O. Box (e exercian ar	Ex	Sequentiatly list cor if any, leading to im cause. Enter Under	mediata tying						1							
	icete be executed physician and s the burial-transit	edicai	Cause (Disease or I that Initiated avants resulting in daath) L		C	CDue to (or as a consequenca of):											
	ding p																
	deeth certi e attending id for use a	clan															
	the d y the	Physiclan/M	Part il. Other algnifi	cant conditions	ontributing to death but not resulting in the underlying cause given in Part I.								tobacco use c			use of death?	
		by PI										10	☐ Yes 2☐ No 3☐ Probably 4☐ Onl				
	law requires t as been signe 2 should be	Completed b										24a. Was an autopsy performed? 24b. Were autopsy tindin aveilable prior to completion of cause of death?					
	0 - 0	Medical Certification: To Be Com										1 Yes 2 No 1 Yes 2 No					
			25. Was case raferr examiner?	(io	26. Place of Death (Check only one)												
	Physician: this certific ral director,		1 ☐ Yes 2 ☐ X		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Special Property of the Control of the C							ther (Specia	fy)				
	ing After fune		27. Manner of Death 1 □ Matural 2 □ Accident	5 Panding investigation	28a. Date (Mo	28b. Time of Injury	njury Wo		ry at 28d. rk? Yes 2 □ No		d. Describe how injury occurred						
	or A offer of ni		3 ☐ Suicide 4 ☐ Homlcida	6 Could not I	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)					28	28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)						
	the Hospital thin 24 hours the Funeral I mpletely filled												usa(s)				
	To the within 2 To the comple		29b. Signature end title of cartifier 29c. License number							29d. Date signed (Month, Dey, Yeer			ier)				
	- S - O		1 Ker	Kerelly M relling D									JULY 6, 1998				
			30. Nama and addra	ss of person who	complated cau	isa of daath (Ite	m 23a) (Type.	Print)									
			KRISHAN						29,	LA PL	ATA.	MD	2064	6			
	Sta Registr		31. Data filed (Mont	1 0 7 19		Pegistrar's Sign					•						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** 2:22 DELLA MAE REIGHARD /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** LIONS MANOR NURSING HOME CUMBERLAND ALLEGANY if Undar 1 Year If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stete or Foraign Country) **Funeral** Days Months 1 🗆 M 214-32-3005 Yrs 102 Director Oct.10,1895 PENNSYLVANIA Usual Rasidance of Dacedant the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits traumetic event, the Medical Examiner must be notified at Yas 2 No Director MD ALLEGANY LAVALE 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 8 23a 2 ROGER WAY 21502 Funeral U.S.A. **Items** 12. Was Dacedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Rece - Amarican Indian, Pages 1 and 2 should be filed within 72 hours effer onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Item Black, Whita, atc 1 ☐ Yas 2√☐ No If Yas, Give Yeer or Datas: 1 ☐ Naver Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No by Specify: WHITE 3 ₩ Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Buainass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) UNKNOWN HOMEMAKER HOME 17. Fethar's Nama (First, Middla, Last) 18. Mothar'a Nama (First, Middla, Maidan Sumame) Be LEWIS LOWERY 2 EMMA LOWERY 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) Depertment of Health ar Important: If Item 27 is any Injury or other trau EMMA GRACE GINGERICH/DAUGHTER 2 ROGER WAY, LAVALE, MD 21502 20b. Pleca of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) RESILAWN MEMORIAL GARDENS 7/6/98 LAVALE, MD 21. Signature of Funeral-Service Licensee 22. Nama end Addrass of Facility UPCHURCH FUNERAL HOME, P.A. ACheec. 202 GREENE ST., CUMBERLAND, MD 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feiture. List only one cause on each line. Approximeta Interval Batween Onset end Deeth **Physician** /Medical Immedieta Causa (Final diseasa or condition rasulting in death) OC DO-COU **Examiner** Dua to (or as a co sequence of): Examiner ician and buriel-transit The law requires that the death certificete be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaasa or injury that initiated events rasulting in daath) Last Due to (or as a consequance physician s the buriel Box 68760, Physician/Medical Dua to (or as a consequance of): as for use P.O. ate has been signed by the a page 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No certificate en 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: director Be 25. Wes case referred to medical axaminar 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) Certification: To 1 Yas this funeral 27. Mannar of Death 28a. Data of injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? Affer 5 Panding investigation 1 Natural 2 Accident s after death. 1 ☐ Yas 2 ☐ No in by the 6 Could not be daterminad 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28a. Placa of Injury - At homa, farm, straet, factory, office building, etc. (Specify) 4 ☐ Homicide Pelli • Funeral Hospital edical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifiar completaly ((Check only one) To the Vithin 2 29c. Licanse number 29b. Signetura end titla of certifier 29d. Date signed (Month, Day, Year)

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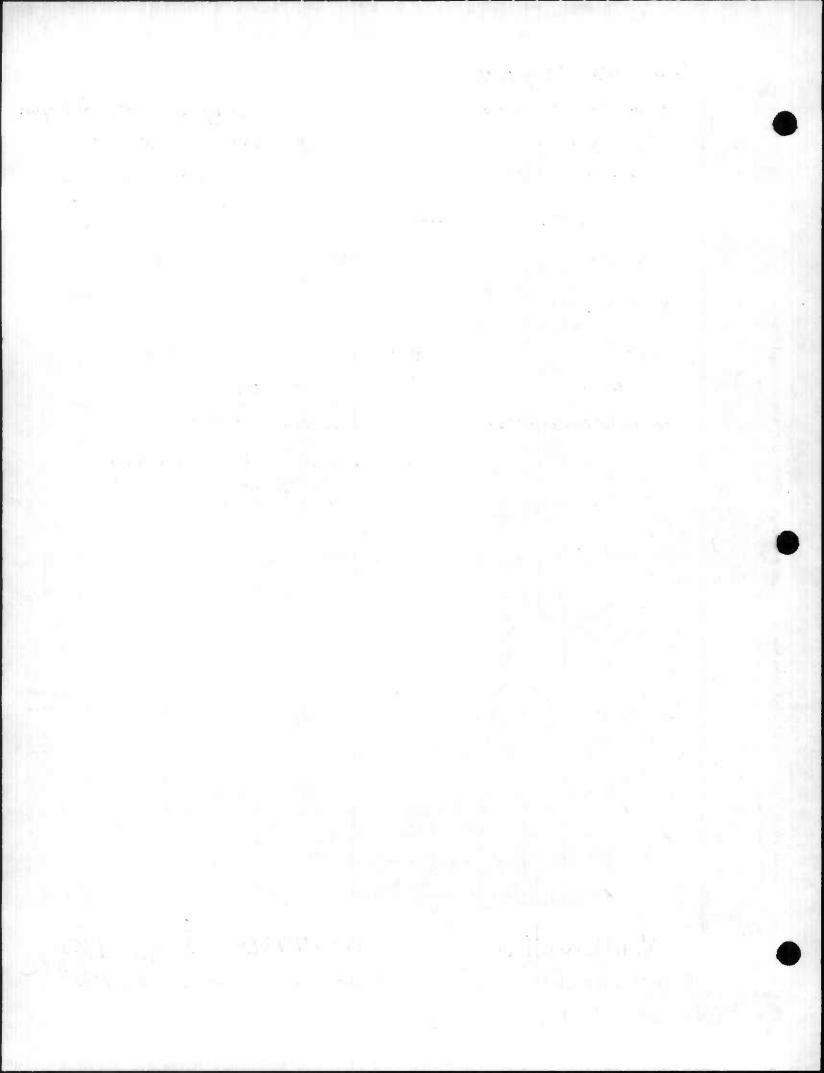
State Registrar 31. Data filed (Month, Day, Year)

JUL 0 6 1998

VA Ranjithan,

Jons Manor Nursing Home, Seton Drive Extended, Comberland
32. Ragistrar's Signatura

30. Neme and addrass of person who completed cause of deeth (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items: 20b,c per F.H.G-761 7/16/98 reb Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth JULY 11, **Physician** 1998 12:55 PM WILBERT H. SHORB /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** SILVER SPRING 2425 BEL PRE ROAD MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Month, Day, Year) MAY 30, 1908 5. Sociel Security Number 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 12 M 2□ F Months Deys Hours MARYL'AND 90 Yrs. 214 03 9790 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, in Medical Examples must be notified at page. 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits MD. MONTGOMERY SILVER SPRING 1 ☐ Yes 2, ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20906 2425 BEL PRE ROAD UNITED STATES Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Raca - American Indian. 11. Marltal Status Bleck, White, etc. 1 Never Married 25 Married Specify: WHITE 1 Yes 2 No Specify: by 3 Widowed 4 Divorcad Completed 16e. Decedent's Usuel Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) Coilege (1-4or 5+) CARPENTER CONSTRUCTION 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) JOHN FRANKLIN SHORB HATTIE CUSTER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 SONATA WAY, SILVER SPRING, MD. WILBERT SHORB, JR. SON 20b. Place of Disposition (Name of cemetery, cremetery or other place) UNION 20e. Method of Disposition 20c Locations VILLE Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from State GEORGE WASHINGTON CEMETERY 7/15/98 ADELPHI, MD. 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licenses MURTE and Address ARBER FUNERAL HOME rher P.O. BOX 5038 LAYTONSVILLE, MD. 20882 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete tritervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · cerebra Vascul Examiner Due to (or es e consequence ot): Examiner physicien end st the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of): 80 for use es signed by the a 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes by 24b. Were autopsy findings evellable prior to completion of cause of deeth? should ! 24e. Wes en autopsy performed? Completed has e 2 s certificate had 1 Yes 2 No Be 25. Was case referred to medical examiner? director 26. Piece of Deeth (Check only one) Hospitel: 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: After 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide

The law requires that the deeth certificate be executed P.O. Box 68760. Division of Vital Records,

Baltimore, Maryland 21215-0020

or Attending Physician: thin 24 hours after death.

the Funeral Director: Af
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> State Registra

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(Check only one)

29b. Signature end title of certified

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Dey, Year) 16 1998 JUL

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1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steled.

Medical Examinar: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s)

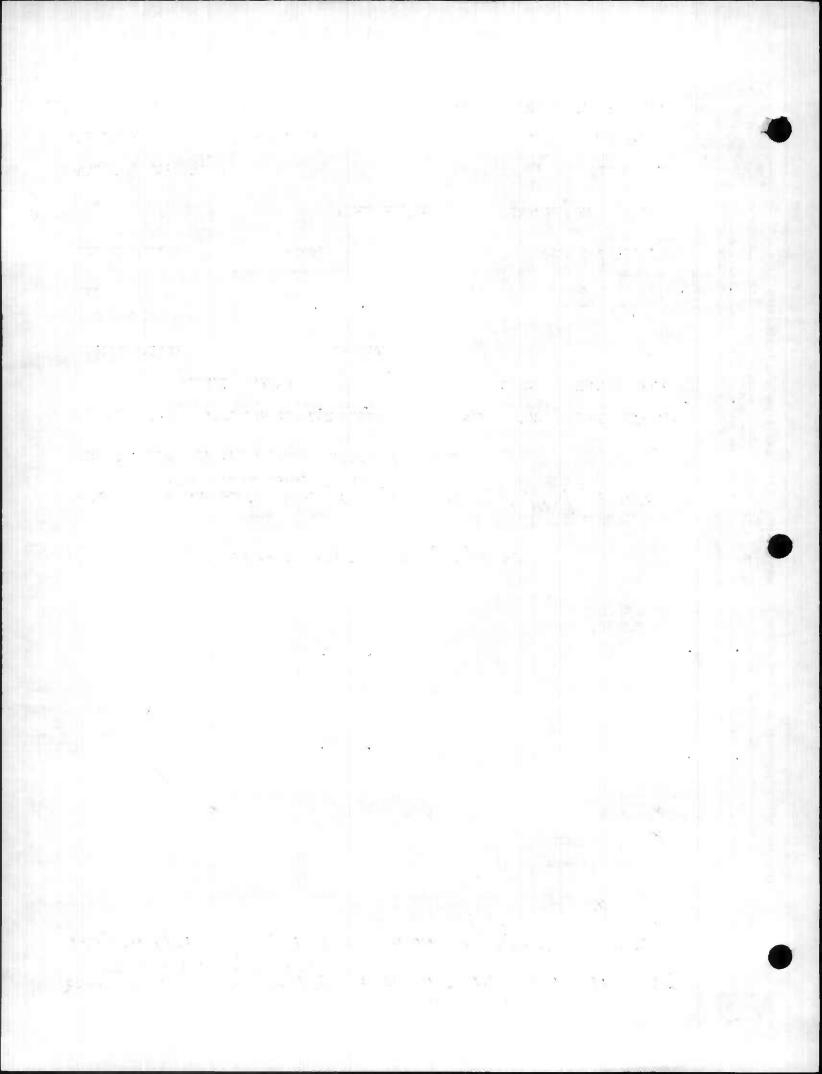
29c. License number

1200458

31/rer Spring md 20

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)



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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per	2 hg	FANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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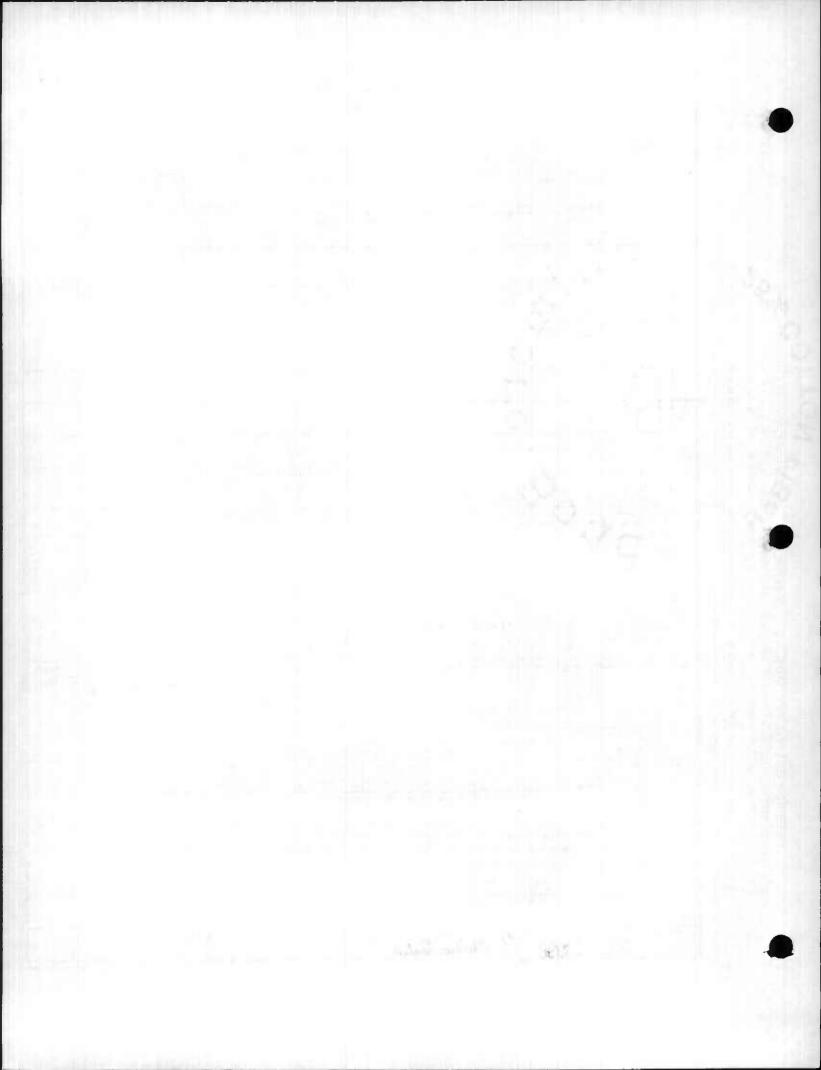
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 22 1998 Richard Douglas Smith June 11:59 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Jan. 24, 218-64-3581 1 X M 2 | F 43 HOURS YRS. 1955 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 11920 Main St. DIRECTOR Libertytown Frederick RESIDENCE OF DECEDENT 10e. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Libertytown 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11920 Main St. 21762 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rica

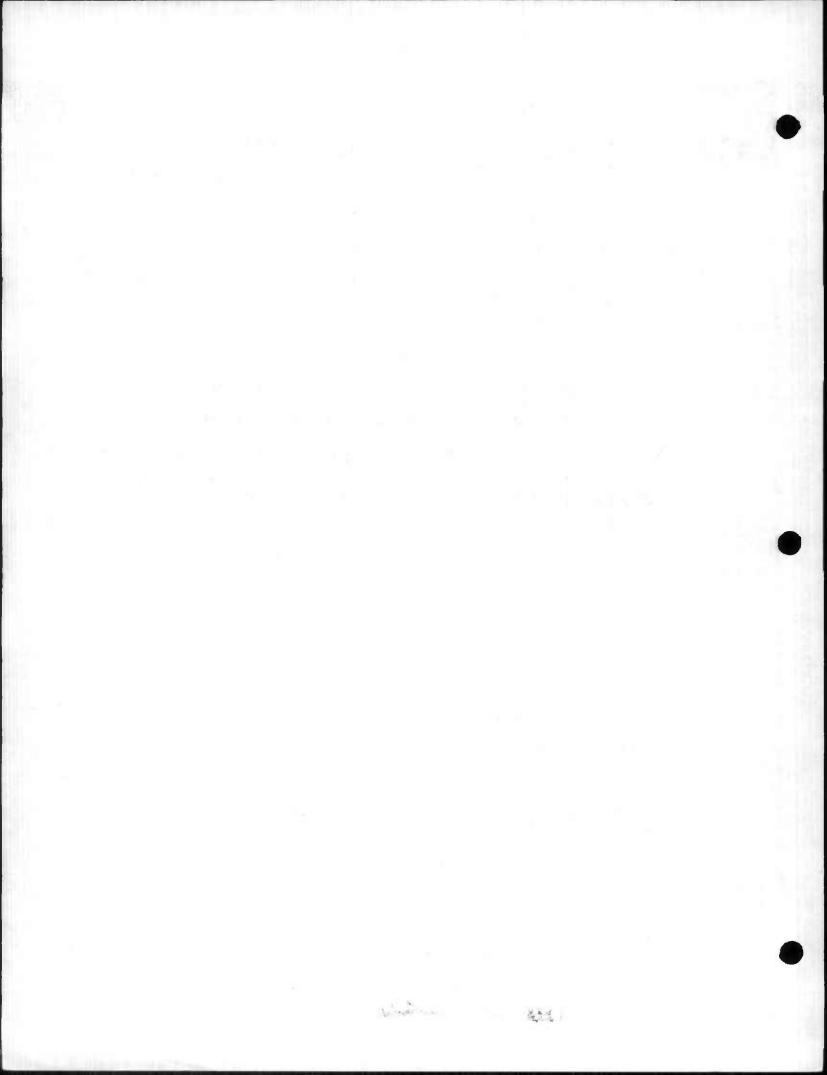
1 YES 2 NO Specify: 1 Never Married 2 Married FORCES7 1 TES & BY 3 Widowed 4 X Divorced Specify: White 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.) College (1-4 or 5+) 12 tractor-trailer driver transportation 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Herman L. Smith Virginia Droneburg 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Amanda M. Smith/ daughter 533 Daisy Dr. Taneytown, MD 21787 20a. METHOD OF DISPOSITION
1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) CROCKY HIII PCemetery 6/30 nr. Woodsboro, MD 22. NAME AND ADDRESS OF FACILITY Hartzler Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSES atharine 404 S. Main St. Woodsboro, MD 21798 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heert failure. List only one cause on each lin Interval Between Onset and Death IMMEDIATE CAUSE (Final To Head disease or condition resulting in death) unshot Wound immedial DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER:
4 | Nursing Home 5 | Residence 1 | Inpetient 2 | ER/Outpetient 3 | DOA 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 1 Netural 5 Pending selfinflicted gunshet June 22, 1989 1 YES 2 NO 1159 BY 2 Accident Investigation 26a. PLACE OF INJURY — At home, term, street, factory, office 3 Suicide 28f. LOCATION (Street and Number of City or Town, State) 6 Could not be determined COMPLETED 4 Homicide nome 11920 Main St Libertytown, MD 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. NATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE D35164 June 26, 1998 2 0. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1080 Westfotrickst Frederick, MD 21703 Andraw LAR Jr MO 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Juli Studer Re



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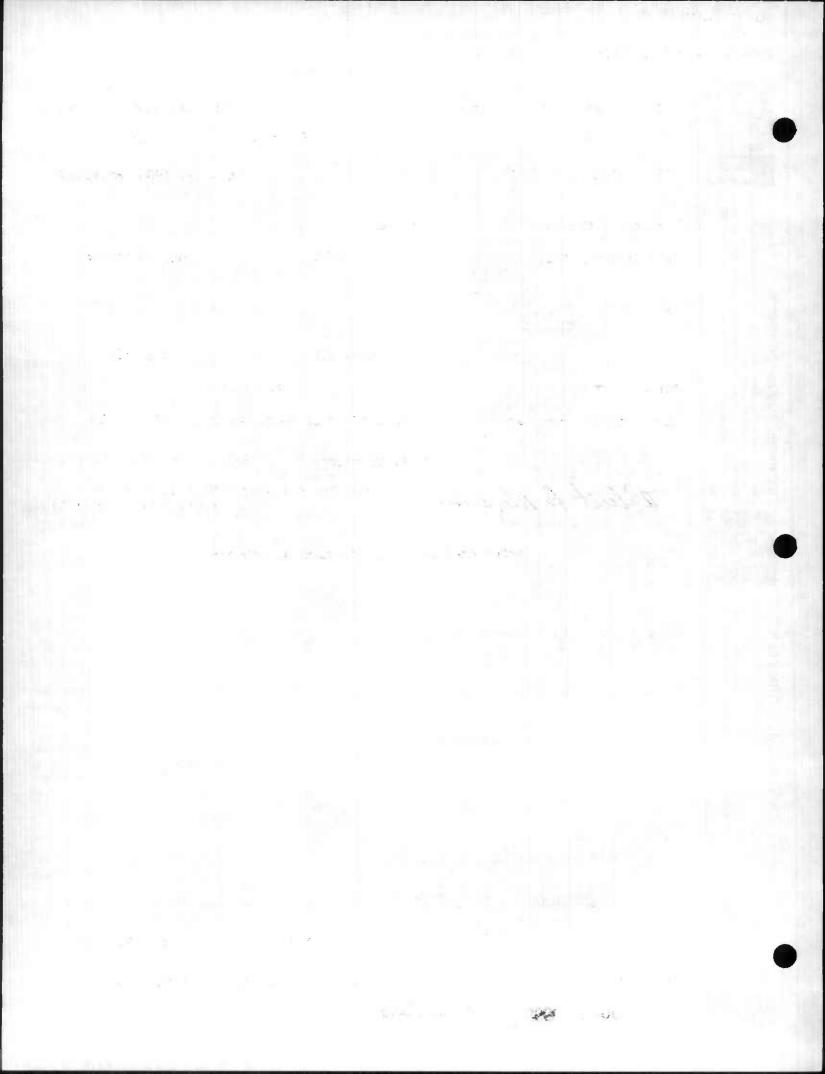
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Registrar

31. Date filed (Month, Day, Year)

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32 Registrar's Signeture



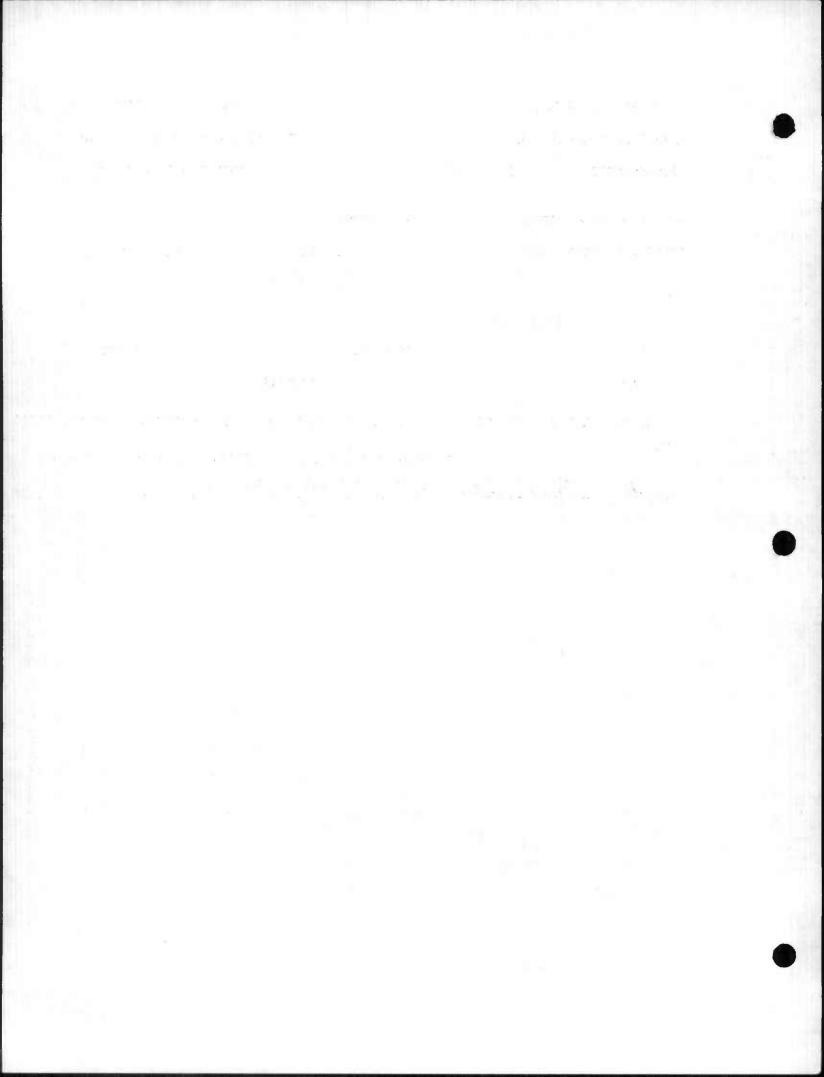
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month LEGHAIYEH SEDAGHAT /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 12331 HATTON POINT ROAD FORT WASHINGTON PRINCE GEORGE 8. Dete of Birth (Month Day, Year) AUGUST 6,1906 IRAN 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Funeral Hours 1□M 2√F 250-59-2282 91 Yrs. Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1√2 Yes 2 No Director MARYLAND PRINCE GEORGE FORT WASHINGTON 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20744 UNITED STATES 10808 RIVERVIEW ROAD deeth Funerai 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or ther any injury or other traumetic event, the Medical Example. 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: IRANIAN 34 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE PRIVATE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) MOHAMMAD ROGHIYEH 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 10808 RIVERVIEW ROAD, FORT WASHINGTON, MARYLAND20744 CHAMAR SEDAGHAT / DAUGHTER 20a. Method of Disposition

✓ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) COMFORT CEMETERY 7/8/98 ALEXANDRIA, VIRGINIA 21. Signature of Funeral Service Licenses THORNTON FUNERAL HOME, P.A. JOHNSON M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND20640 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final anemia disease or condition resulting in death) Examine Due to (or as a consequence of): Examiner ician and buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): physician s the buriel Fidy P.O. Box 68760. Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yes 20 No Division of Vital 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home \$ Aesidence 6 Other (Specify) 1 Yes 2 No this funeral 28a. Date of Injury (Month, Dey Year) 27. Manget of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

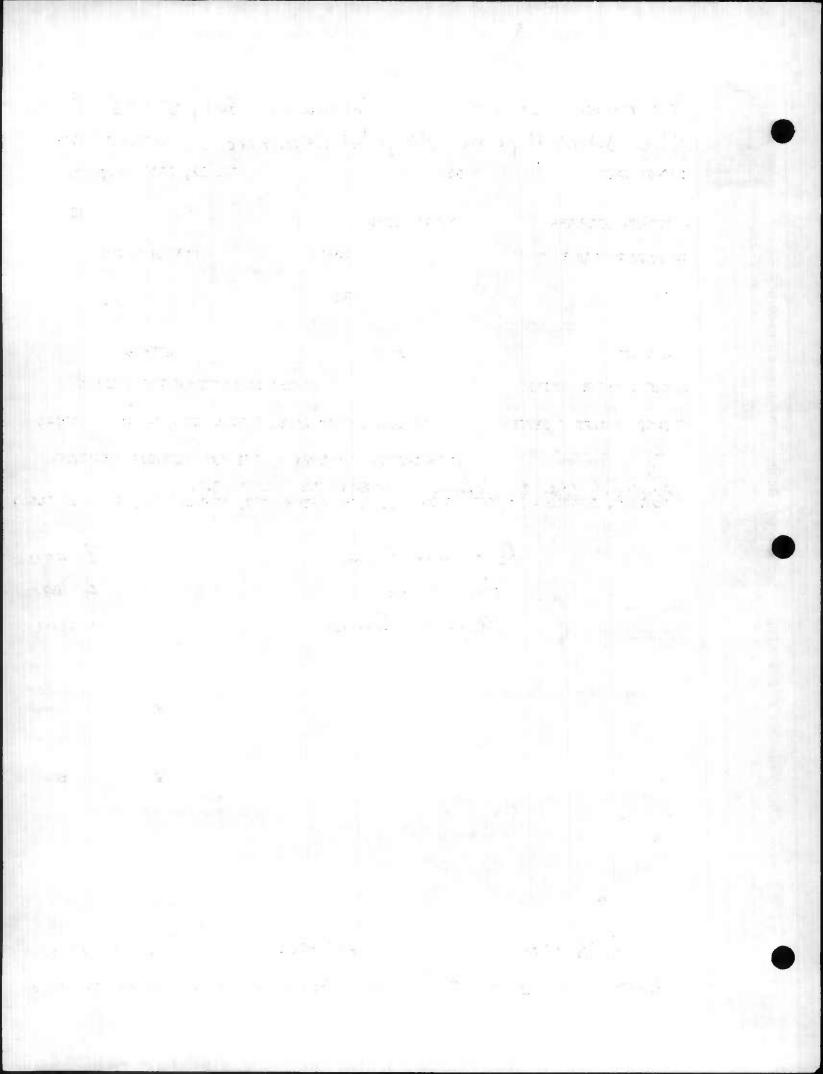
| Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 045365 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Saderier, MD., 11701 Livingston Road Suite 101 Ft. Washington, MD 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State John Studen Randall JUL 0 7 1998 Registrar



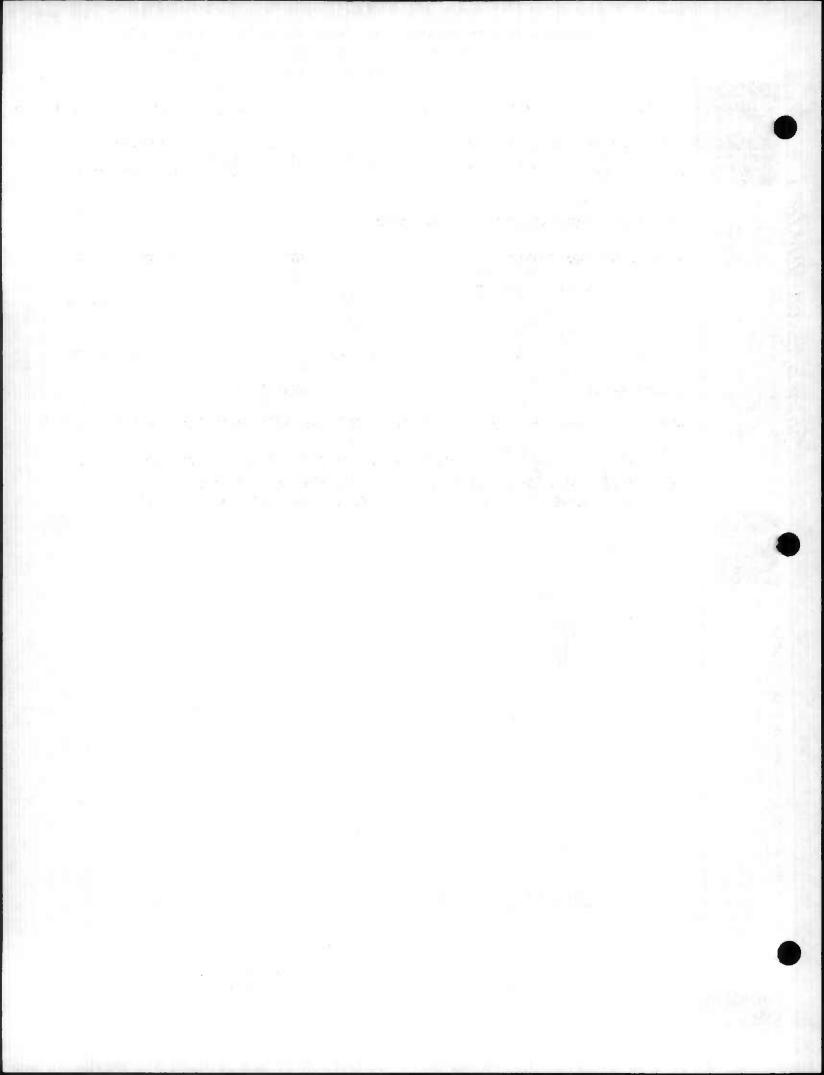
			State of Maryla		ertificate			Reg. No.	8 21921
Physicia /Medic	al	1. Recedent's Neme (First, Middle, Last RAYMONO C	LIFTON		Sh	JAILES AN SIN TOWN OF	2. Dete of De	1 5,19°	3. Time of Death 8:35p
Examin Funeral Director	er	4e Fecility Neme (If not Institution, giva The Johns 5. Sociel Security Number 220-28-6089 6. Se	Hopkins	Hos s. lest birthda Yrs.	Pital Months D	Battim	OrC.s. 8. Dete of Bi	BALT	IMORE CITY 9. Birthplece (State or Foreign Country) MARYLAND
Maryland a-f show	tor	Usual Residence of Decedent 10e. State 10b. County MARYLAND CHARLES		City, Town or					10d. Inside City Limits XXYes 2 □ No
vith the	Director	10e. Street and Number			10f. Zip Co			10g. Citizen of V	
I 5-0020 72 hours after death with the Manyland *natural*, or frams 23a or 28a-f show adical Examiner must be notified at	by Funeral	11. Maritel Status XXNaver Merried 2 Merried 3 Widowed 4 Divorced	L: 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ŽUŽNo ff Yas, Give Yeer or Detes:	U,S. 1:		0640 of Hispanic Origin? (Cuban, Mexican, Pue (No Specify:			e - Americen Indien, k, White, etc.
2121 ad within sgiana. or then	Completed	15. Decedent's Edu (Specify only highest gred Elementery/Secondary (0-12) 6TH GRADE		(Gi	cedent's Usuel O ive kind of work o b. DO NOT use r OOK	one during most of westired)		PRIVAT	
S S IS S S	To Be	17. Father's Neme (First, Middle, Last) JAMES MADISON SWAI				MARTHA	ELIZABET	H GWYNN	SWAILES
Imore, Ma Pagas 1 and 2 s nant of Haalth ar int; if New 27 is ury or other trau		19a. Informent's Neme/Reletionship (T) VIOLET SWAILES / S 20e. Method of Disposition 1 № Buriel 2 □ Cremetion 3 □ F 4 □ Donetion 5 □ Other (Specify) 21. Significant of Funeral Service Ucens	ISTER 20b Removel from State	18 E Plece of Dis cematery, o	AST POPI sposition (Neme rametory or othe TION CEN	r place)		EAD, MAR 20c. Location -	
Physician /Medical Examiner	J6	23a. Pert1. Enter the disease, cromping shock, or heert feilure. List only of the disease or condition resulting in deeth)	RESPIRAT	D583 Beth. Do not	439 LIV		AD, INDI	AN HEAD,	MARYLAND 2064 Approximate Intervel Between Onset and Deeth Z 0475
. BOX b6/bU, death certificate be asscuted a sitending physician and of for use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	PROST	472	sequence of): ANCE sequence of):	R			L DAYS YEAR
d by th	y Physiclan/M	Pert II. Other significant conditions con	ntributing to death but not re	esulting in the	e undarlying ceus	e given In Pert I.		tobacco use co	ntribute to the cause of death?
a law requiras has been sign	Completed by						24e. We	s en eutopsy ormed?	24b. Were eutopsy findings aveileble prior to completion of cause of deeth?
OT VI(al RECORDS, Physician: The law requires the cartificate has been signe that director, page 2 should be a	Be	25. Wes case reterred to medical exeminer?	Hospitel:			Othor	eeth (Check only		1 ☐ Yes 25€ No
Phys Of	atlon: To	1 Yas 2 No 27. Menner of Deeth 1 Neturef 5 Pending 2 Accident Invastigation	28e. Dete of Injury (Month, Dey Year)	28b. Time Injur		Injury et Work? 1 Yes 2 No	7	how injury occur	
2 9 # 2 E	Certification:	3 Sulcide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, farm,	street, fectory, o	ffice	28f. Location City or To	(Street and Numb own, State)	per or Rural Route Number,
To the Hospital within 24 hours a To the Funeral complately filled	edical		sician: To the best of my k ner: On the basis of exami end menner steted.						
To the within 2 To the comple	Me	29b. Signeture and title of certifiar	Mo			cense number		-	d (Month, Day, Year) 5 1998
,		30. Name and address of person who co	ompleted cause of deeth (It	em 23a) (Typ	JOANS	HOPKINS	Hospim	c, Bgs.	5, 1998 TIMORE MO

State Registrar

BROY I.W 31. Dete tiled (Month, Dey, Year) 32. Registrar's Signeture JUL 0 7 1998



			State of Maryla		rificate of			giene Reg. No.	8 21922
Physic /Medi		Decedant's Nama (First, Middla, Last, FRED MIC		AMEN			2. Data of De Month July	ath Dey 3. 199	Year 8 10:15 a
Exami		4a. Facility Nama (If not institution, giva				4b. City, Town, o	or Location of Deetl	4c. County	
	м	Civista Medica			K Hadas 4 Vass	La Pla		Char	
Funeral Director		5. Social Sacurity Number 097-18-5116 Usual Rasidence of Dacedant	7. Aga (In yrs	Yrs.	If Undar 1 Yaar Months Days			th y, Year) 1913	Birthpleca (Stata or Foraign Country) NEW YORK
land w		10a. Stata 10b. County	10c. C	ity. Town or Loca	ation				10d. insida City Limits
Me I	ţō	MARYLAND PRINCE GI	EORGE 'S	ACCOKE	EK				1 ☐ Yas 2X No
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizan of V	What Country?
23a		15703 BLACKBURN ST	TREET			20607		UNITE	D STATES
n 72 hours after death with the Meryland *naturel", or flems 23s or 28s-f show	by Funeral	11. Marital Status 1 □ Navar Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Evar in the Armed Forcas? 1 ☐ Yas 2 ☒No If Yas, Giva Yaar or Datas:	lf '	as Decedant of l Yas, specify Cub □ Yas XX No	an, Maxican, Pu	(Specify Yas or No arto Rican, atc.)	- 14. Rac Blac Specify	a - Amarican Indian, ck, Whita, atc. WHITE
C .	Completed	15. Decedant's Edu (Specify only highast gradi Elementery/Secondary (0-12)		(Giva ki	nt's Usual Occu ind of work dona O NOT usa retire	during most of w	vorking	16b. Kind of Bu	usinass/industry
0 0 2 .		12	0	OWNER	OPERATO		450		E STATION
ed ita	To Be	17. Fathar's Nama (First, Middla, Last) ALBERT SAMEN				ANNA	ama (First, Middla, SAMEN	Maidan Sumer	99)
the man		19e. Informant's Name/Reletionship (Ty					Rural Routa Numb		
E = 64 .		BEATRICE W. SAMEN				RN STREE	T, ACCOKI		
S 2 T		20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ R	lamoval from Stata	Place of Disposi cematary, crams	atory or other pla		Data		City or Town, Stata
it. Partmer		4 Donation 5 Other (Specify)	$\frac{\text{CHR}}{2}$						OKEEK, MD
permit. Page Department of Important: If any injury or once.		21. Signat de Lunar L. Sary de Licedson MGB MARK G. BROHAV	MO0053			_	HOME, INC RF, MARYI		604
Physician /Medical		23a. Part1. Entar tha disaasa, or compli shock, or heart failura. List only or Immediata Cause (Finel						rrest,	Approximata Interval Between Onsat and Death
Examiner		disaasa or condition rasulting in daath)	Dua to (or as a consequ	enca of):	preum	NOPIMS		unknown
bed sit	nine	_ t)	Vanca	liti's				unknown
execution and end rial-trans	Examiner	Sequantially list conditions, if any, leading to Immadiata cause. Entar Undarlying Causa (Disaase or Injury	Dua to (or es e consequ	ance of):				
rificete be executed ng physician end es the bunal-transit	Medicai	that initiated events rasulting in death) Last	,	or as a consequa	anca of):				
death certific e attending p	an		J						
0 0 %	Physician/M	Part II. Other aignificant conditions con	tributing to death but not ra-	sulting in the und	larlying causa gi	van In Part I.	23b. Did	tobacco usa co	ntributa to the cause of death?
8 g	by Phy	Coronara	artery o	discon	۷		10	Yes 2⊠No	3 □ Probably 4 □ Unknown
aw requisite been 2 should	Completed	chronic	conemic					an autopsy rmad?	24b. Wara autopsy findings available prior to completion of cause of death?
Page Page	ပ္						10	ras 20 No	1 ☐ Yas 2 ☐ No
ysician: The	Be	25. Wes case referred to medical exeminar?	la anital.				eeth (Check only o	one)	
0 0	- To	1 ☐ Yas 2 Ø No 27. Menner of Deeth	lospital: 1 Inpatient 2 2 28a. Data of Injury	ER/Outpatient	3LI DON		Homa 5 □ Rasi		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	1 ⊠ Netural 5 □ Panding 2 □ Accidant invastigation 3 □ Sulcida 6 □ Could not be	(Month, Day Year)	28b. Tima of Injury		rk?]Yas 2□No		now Injury occur	
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he Hosp in 24 hou he Funei pletely fil	edical	29a. Cartifier Check only one) Cartifying Physical Cartifying Phys	alctan: To the best of my knowner: On the besis of exemine and mannar stated.	owledga, daath o etion and/or Inva	stigation, in my	ma, deta and pla opinion, daath oc	ce, and due to the curred at tha tima,	ceuse(s) end ma date and piece,	annar as stated. and dua to tha causa(s)
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		/ /	m !		D-38	388		7/3/	48
		30. Name and addrass of person who co Sunil Nachnani		m 23a) (Type, Pr	0,2	o Woody	ard Rd. Maryland	Suite	601
Sta	te	31. Data filed (Month, Day, Year)	32. Registrar's Sign	atura	0211		7	20133	



State of Maryland / Department of Health and Mental Hygiene 98

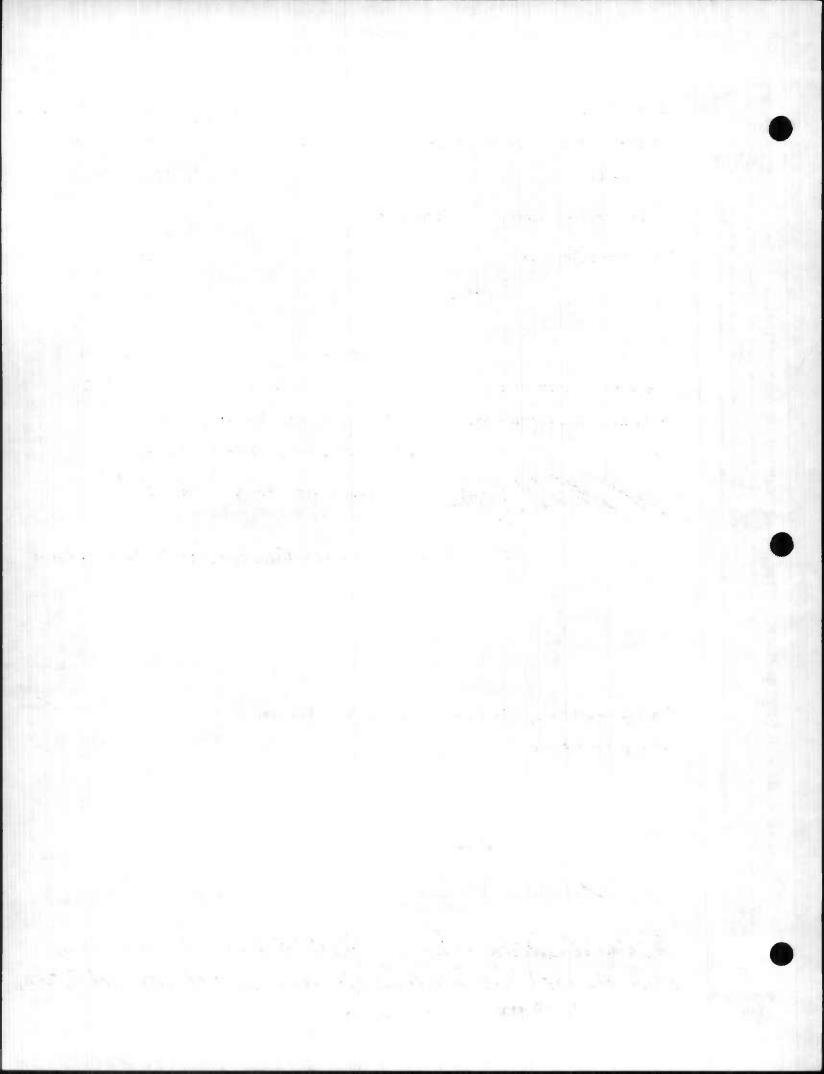
					Cel	lineale o	Dealli		Reg	g. No.		
Physicia /Medic		Decedant's Name (First, Middla Zelda Viola							Data of Death Month 11y 7,	Day 1998	Yaar 3	3. Time of Death 7:16 a.m.
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	п	Prince George'	s Hospita	al Cent	er		Chev	verly		Pri	ice G	eorge's
Funeral			6. Sex	7. Age (In yrs.		if Undar 1 Yas	ar if Undar		Data of Birth Month, Day, 1			ace (State or Foreign
Director		578 10 4381 Usual Rasidance of Dacedant	1□M 25□F	83	Yrs.	Months Day	s Hours		ar 27,		VA	ry)
Du B		10a. Stata 10b. County		10c. Ci	ty, Town or Lo	cation					10	d. Insida City Limits
illed within 72 hours aftar death with the Manyland Hygiene. Ther than "naturel", or flerns 23a or 28a-f ahow ent, the Medical Exameral must be nothed at	Funeral Director		George's	s Gr	eenbel							1 Yas 2□No
ith th	Oire	10e. Street and Number				10f. Zip Code			10	g. Citizen of \	What Count	iry?
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90	ne	11. Marital Status	12. Was Dace Armed Fo	edant Evar in U	J,S. 13.	Was Decedant o	f Hispanic Ori	igin? (Specify	Yes or No-		e - Amarica	
or, or the	by	1 Nevar Married 2 Marrie 3 Widowed 4 Divorced		2 √ XNo		1□Yas 2□ _X N					whi	
naturel, or	Completed	15. Decedant' (Specify only highas)	s Education grada completed)		16a. Dece	dant's Usuel Occ kind of work dor DO NOT usa reti	upation na during mos	t of working	10	6b. Kind of B	usinass/Ind	lustry
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h and Mental Hygiene. 7 is marked other than traumatic avent, the M	To Be	Bernard Oliv	er Will:	is			Gali	ilee			Hi	cks
and Men is marke sumatic		19a. Informant's Name/Ralationsh	ip (Type, Print)		19b. Meili	ng Address (Stre	et and Numbe	er or Rural Ro	uta Number.	City or Town,	Stete, Zip	Coda)
n 27 la		Debra A. Norton	/grandda	ug.	1950	Aberde	en Dr.,	, Dunki	irk, MI	20754	4	
五百名		20a. Mathod of Disposition		State MD	Piace of Dispo cametary, crei	esition (Nama of matory or other p nal Mem	Park	7-9-		Oc. Location -		wn, State
Department of Important: If any Injury or page	-	4 Donetion 5 Other (Sp 21. Signature of Funeral Service L		- 1	01	2. Nama and Ado	trace of Escilli	that the same of t				
Depa Impo any I		21. Signature of Funeral Service a	11/	24					Orrinas	MD	2073	6
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certificate be executed nding physician and use as the burial-transit	icai Examiner	Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Causa (Diseasa or injury that initiated avants	b		or as a consec							
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e io		Part ii, Other significant condition	A contributing to de	eath but not res	sulting in the u	ndedving cause	given in Pert i	1	23b. Did tob	acco use co	ntribute to	the cause of death?
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ate has been signed by the atter paga 2 should be datached for	d b								24a. Wes an	autopsy	24b. Wa	are eutopsy findings
been si	ete	depende	nce						pertorm		eva con	aliabla prior to
S C/	dr										of c	death?
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is certificate director, par	Be	25. Was casa referred to medical axaminar?				1.		e of Daath (C	heck only one)		
Ø 0	2	1 Yes 2 No	Hospital: 1 🗆	inpatiant 2	ER/Outpaties	nt 3 DOA	Othar: 4 Nu	ursing Homa	5 Rasider	nce 6 Oth	ar (Specify	1)
h. After th funaral		27. Manner of Death 1 ☑Natural 5 ☑ Panding	28a. Data (Mon	of injury th, Day Year)	28b. Tima o Injury	f 28c. In	jury at Vork?	28d.	Describa hov	w injury occur	rad	
or death. octor: After this certific by the funeral director,	atio	1 ☑Naturai 5 ☐ Panding 2 ☐ Accident investig		114	, , , , ,		☐ Yas 2☐	No				
after death. Director: After I in by the fune.	Certification:	3 ☐ Suicida 6 ☐ Could n 4 ☐ Homicida determin	and 286. Piece	of injury - At h ng, etc. <i>(Spaci</i>	iome, ferm, st	reet, factory, offic	28	28f.	Location (Str. City or Town,	eet and Numi Stete)	oer or Rura	l Routa Number,
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within 24 hours after To the Funeral Dir.	TO		and main	rui otatau.								
₹ 6	Med	29b. Signature and title of certifier			_	29c Lice	nsa number		29	d. Data signa	d (Month.	Day, Yaar)
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Talia Davidson Radall

State

Registrar

31. Data filad (Month, Day, Year) JUL 08



State of Maryland / Department of Health and Mental Hygiene

					ary larra /	Certificate	of Death		g. No.	4	924
	6 1		1. Decedent's Neme (First, Middle, L	ast)				2. Dete of Death Month	1	'ear 3.	. Tima of Deeth
	Physici /Medi Examir	cal	Thomas Ralph Sm 4a. Facility Neme (If not institution, go 4102 1st Street	ithson, Sr va street and number)	•		4b. City, Town, o	July 2,	1998 4c. County of Calve	Deeth	5:15 A.M.
٢	Funeral Director				ga (In yrs. lest bi	Yrs. If Under 1 Months [Yeer If Undar 24 Ho Pays Hours Mi	8. Dete of Birth n. July 10), 1942	Birthplace Country) Washir	(State or Foreign
	and		Usuel Residence of Dacedent 10a. Stata 10b. County		10c. City, Tov	vn or Location					Inside City Limits
	Maryi -f aho	tor	Maryland Calver	t		Beach					1 ☐ Yes 2√ No
	th with the 23a or 28a ast be not	Funeral Director	10e. Street and Number 4102 1st Street			10f. Zip C 2071			og. Citizen of Wh Inited S		
21215-0020	filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or itams 23a or 28a-f ahow ant, the Modical Examinat must be not fed at	þ	11. Marital Status 1 ☐ Never Married 2√7 Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forcas? 1 ☐ Yes 2 ☐ If Yes, Give X Yeer or Dates:		13. Was Deceder If Yes, specify	t of Hispanic Origin? (Cuban, Maxican, Pue No Specify:	(Specify Yes or No- erto Rican, etc.)		American li White, atc.	
15-0	I within 72 ho iena. • than "netui the Med cel	Completed	15. Decedent's E (Specify only highest g		166	Decedent's Usual ((Give kind of work	occupation fona during most of w etired)	orking	6b. Kind of Busi	ness/Industr	у
2121	within ena.	dmc	Etementery/Secondery (0-12)	College (1-4or 5)+)				0		
	2 should be filed withing and Mental Hygiena. Is marked other than aumatic avant, the Mental avant, th	Be Co	8th grade 17. Father's Nema (First, Middle, Las	t)		ecurity Gu		eme (First, Middle, N	Securit		
Maryland	d 2 should be filed th end Mental Hyg 7 is marked other traumatic avant,	To	William Smithson	1			Elain	e Reily			
Mar			19a. Informant's Neme/Reletionship				treet and Number or I				•
	leal leal		Helen Smithson 20a. Mathod of Disposition	(wiie)	20b. Pteca d	of Disposition (Neme	reet, Nor		Mary Lan		
Baltimore,	nit. Page entment c ortant: If injury or		1 Buriai 2 Cremation 3 4 Donetion 5 Other (Spec	hsee I	nt Ceda	22. Neme end	netery July	6, 1998	Suitlan	d, Mai	ryland
	Ded Grand		> St. S. 5)ith		8125 Sou	thern Md.	Lee Funera Blvd., Ow	rings, M	arylar	nd 20736
	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart feiture. List only immediate Cause (Finel disease or condition					ac or respiretory erre	st,	Apr Inte One	proximete erval Between set end Deeth
	Examiner	_	resulting in death)	a	Due to (or as a	obstructions consequence of):	11017				
Box 68760,	eath certificate be executed attending physician and for use as the buriel-transit	Physician/Medical Examiner	Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated evants resulting in death) Lest	c	Due to (or as a	consequence of):	geal Cor	cinoma			
	0 0 0	sicia	Part II. Other significant conditions	contributing to death be	ut not resulting	in the underlying cau	se given in Pert I.	23b. Did tol	bacco use contr	ibute to the	cause of death?
s, P.O	requires that the de seen signed by the a hould be detached to	by Phy	Cachexia					1 🗆 Ye	s 2□ No 3	Probabl	y 4□Unknown
Record	2 S W	Completed	Ca chexiu hypercoagu	lable sta	ate			24a. Was ar perform		aveileb	autopsy findings ble prior to ation of cause th?
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Vital	Physician: The this certificate rai director, pag	Be C	25. Wes case referred to medical examiner?	Hospitet:			Other	eeth (Check only one			
of		п: То	1 ☐ Yes 2 ☐ No 27. Manner of Death	28e. Date of Inju	ry 28b.	utpetient 3 DOA	Injury at Work?	Home 5 Aaside			
ion	Attending r deeth. sctor: After by the fune	atlo	1 Naturel 5 ☐ Pending 2 ☐ Accident investigation		y Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No				
Division	tal or Attendir is after deeth. al Director: Al ed in by the fu	Certification:	3 Suicide 6 Could not l		ury - At home, for a (Specify)	erm, straet, factory, o	ffica	28f. Location (Str City or Town		or Rural Ro	ute Number,
	To the Hospital or Atl within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying P	nysician: To the best of miner: On the bests of end menner sta	examinetion ar	e, death occurred et nd/or investigetion, in	he time, dete end ple my oplnion, deeth oc	ce, and due to the ce curred at the time, de	use(s) and manr ite and place, an	er as stated d due to tha	f. cause(s)
	To the within 2 To the comple	Σ	29b. Signetura and title of certifier	0		29c. L	cense number		d. Data signed (Year)
			30. Name and eddress of person who	In gerne		(Time Pital)	41)61		JULY 2,		
			Beth R. Mizer	· · · · · · · · · · · · · · · · · · ·	55 Sh	oakleu K	d. Princ	e Frecker	ick , mi	D. 20	7678
	Sta		31. Dete filed (Month, Dey, Year)	32. Registra	ar a aidilleraile	- 4					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 07 JULY **Physician** 1998 10:55A Emma Mary Soethe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Allegany Sacred Heart Hospital Cumberland If Under 1 Year 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) Days **Funeral** Months 1□M 20 F Hours Nov 4, MD Director 90 218-50-0544 Usuel Residenca of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is merked other than *natural*; or itams 23a or 28e-f show any Injury or other traumatic event, the Medical Emerican 10c. City, Town or Location 10e. Stete 10d, Inside City Limits 10b. County Yes 2 No Director Cumberland Allegany 10e. Street and Number 10f. Zlp Code 10a, Citizen of Whet Country? 401 Columbia Street 21502 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, 12. Was Decedent Ever In U,S. Armed Forces? Bleck, White, etc. Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 🏠 No Specify: Specify: by 3 Widowed 4 □ Divorced Year or Detes: white Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadant's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17 Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Joseph Grabenstein Margaret (Stacer) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) 32 Allegany Street Lonaconing MD 21539 Emma Nightingale-daughter 20b. Plece of Disposition (Name of cemetery, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State SS Peter Paul Cemetery 4 ☐ Donetion 5 ☐ Othar (Specify) 07/09 Cumberland MD 22. Name end Address of Fecility 21. Signeture of Funerel Se vica License Scarpelli Funeral Home, P.A. Cumberland MD 21502 23e. Part 1. Enter the disease, or complications that caused the doubt shock, or heer feiture. List only one cause on each line. Do not enter the mode of dylng, such as cardiac or raspiretory arrest, Approximate Intervel Batween Onset and Deeth Physician /Medical Immediete Cause (Finel diseese or condition resulting in deeth) **Examiner** Examiner ettending physician and for usa as the burial-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disaasa or injury that initioled events resulting in deeth) Lest Dua to (or es e consaquence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by the 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evellable prior to completion of cause of death? 24e. Wes en eutopsy Completed ate has t 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: funeral director, Be 25. Was case rafarred to medical axeminer? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 ☐ Yes 2 ☑ No 1€ Inpatient 2 ER/Outpetient 3 DOA Certification: To After this 28c. Injury et Work? 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 5 Panding investigation 1 Naturel after death. 2 No 2 Accident 3 Suicida 6 Could not be datarmined 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicida To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Scrifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Cartifian 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and titla of certifier 2532 JULY Print) George Breza m.D MD 21502 of deeth (Item 23a) (Type, Print) umber 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene 2/926 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 3 1998 MICHAEL ANTHONY SPATARO, SR. JULY 4:10 A.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. Birthplaca (Stata or Foreign Country) 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Yrs. 188 16 6955 Director JULY 10 1922 MARYLAND Usual Residence of Decedent the Menyland 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or hams 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter deeth with 1 Department of Health and Mental Hygiens.
Important: If Itam 27 is marked other than "naturel", or thems 23s or 2 any injury or other traumstic event, the Medical Experience 23s or 2 Mode. 19211 KAEFER ACRES DRIVE 21532 U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Evar in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE P 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry INC. Elementary/Secondary (0-12) College (1-4or 5+) BRICKLAYER NATIONAL MASONARY CO. 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 LOUIS SPATARO RACHEL PARILLO 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) MARGARET SPATARO / WIFE 19211 KAEFER ACRES DRIVE, FROSTBURG, MD 21532 20a. Method of Disposition

1 Burial 2 Cremetion 3 Removel from State 20b. Plece of Disposition (Neme of cematary, crametory or other plece) 20c. Location - City or Town, State FROSTBURG, MD 21532 FROSTBURG MEMORIAL PARK 7/6/98 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signeture of Funeral Service Licensee SOWERS FUNERAL HOME, P.A., 60 W. MAIN ST., Duers 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

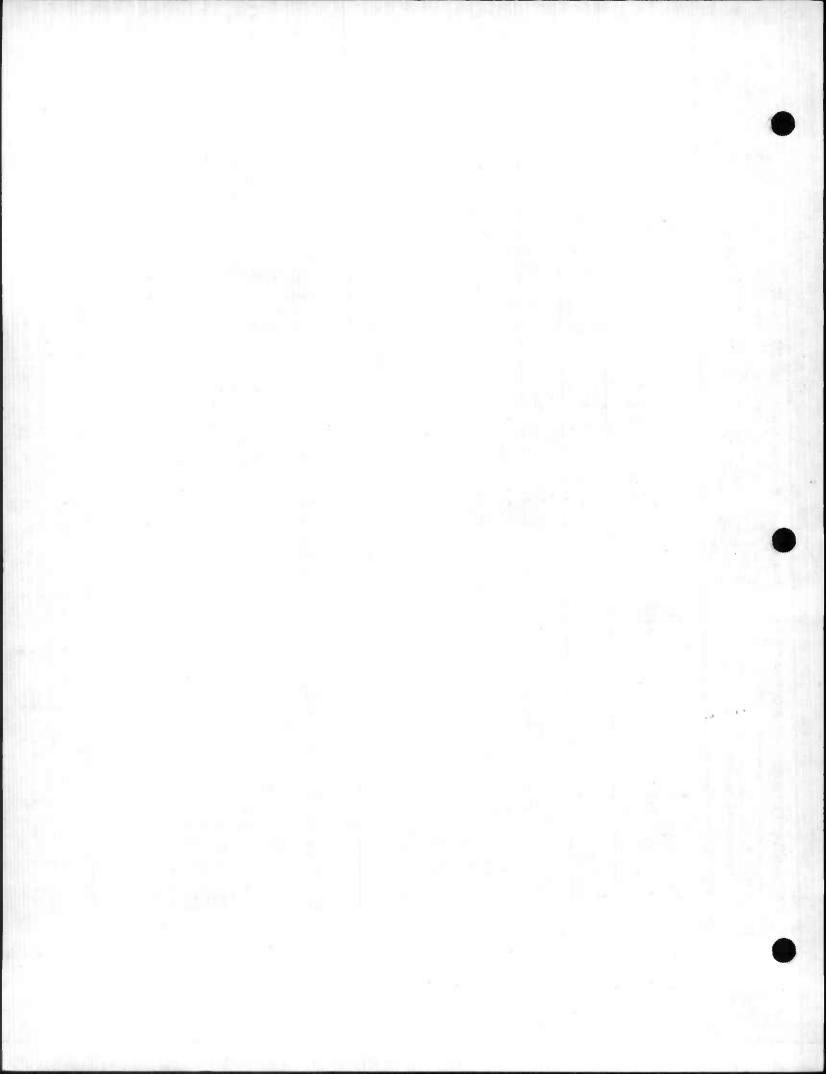
Approximate shock, or heart failure. List only one cause on each line. Interval Between Onsat end Death **Physician** /Medical tmmediate Cause (Finel 5 days disease or condition resulting in death) Examiner ician and buriel-transit Examin Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): physician at the buriel Box 68760 Physician/Medical Dua to (or as a consequence of) 980 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobecco use contribute to the cause of death? Records, P.O. ŝ signed by t 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 Minknown Sepsis þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? Deen has page 2 1 Yes 2 10 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? Other: Nursing Home 5 Residence 8 Other (Specify) Hospitel: 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Certification: 27. Manuer of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funerel Director: After 1 Wintural 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. 29e. Certifier edical completely, (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of contilior 021244 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) The JESUS H. TAN, M.D., FROSTBURG PLAZA, FROSTBURG, MD 21532 31. Date filed (Month, Day, Year) 32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar

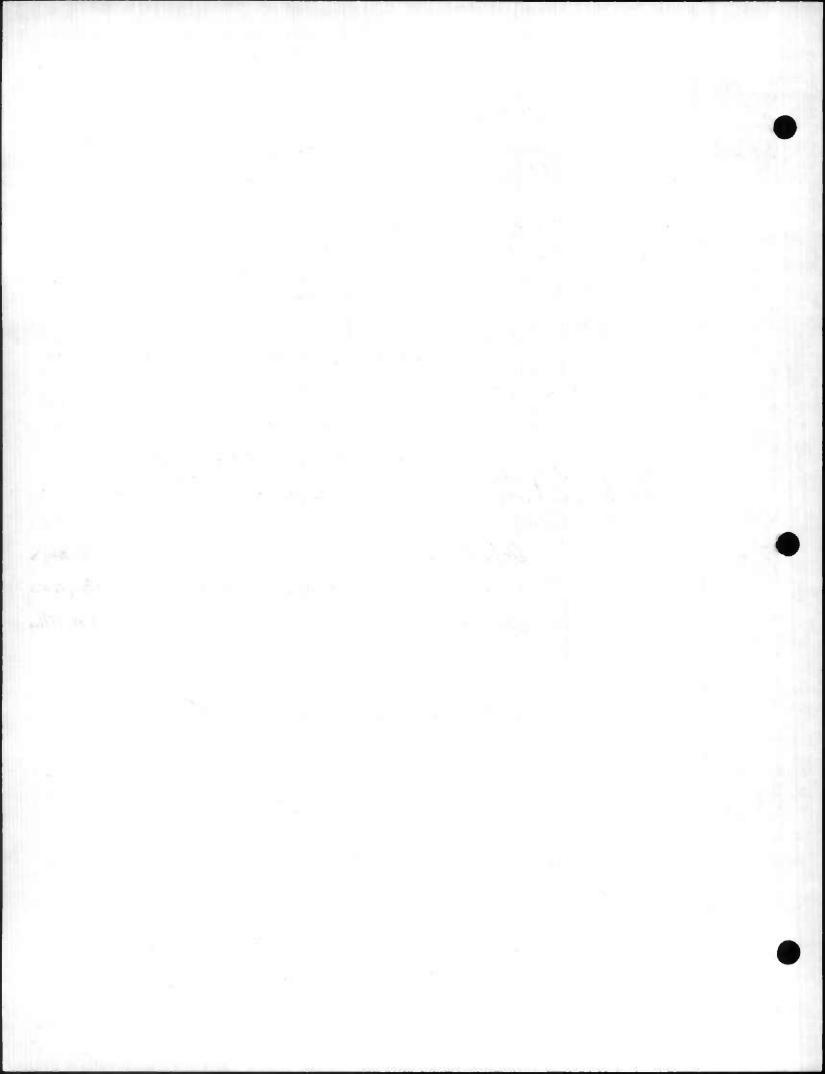
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П	Dharini		1. Decedent's Name (First, Middle, Las	t)					2. Date of Deal	th	Year	3. Time of E	Death
1	Physici /Medi		Robert D. S						Jul.	5, 19	98	2:10	AM
	Examir	ner	4a. Facility Name (If not institution, giva						Location of Death	4c. County of			
H	Formul		Avalon Nurs 5. Social Security Number 6. Se		n yrs. last bi	rthday) If Ur	nder 1 Yaar	Hagerst		Wash			Fornian
L	Funeral Director			M 2□F 82		Yrs. Mont	ths Days	Hours Min	8. Date of Birth (Month, Day) Jul 31	Year) , 1915	Mar	aca (State or ry) yland	l
	how		10a. Stete 10b. County	10	c. City, Tow	m or Location					10	d. Inside City	Limits
	e Me	ctor	Maryland Washin	gton	На	agerst	own					1 Yes	2□No
	th with th	Funeral Director	10e. Street and Number 16952 Shade Br	ook Terra	ce	10f.	Zip Code 217	40	1	0g. Citizan of W USA		ry?	
21215-0020	72 hours after deeth with the Meryland "natural", or ferms 23a or 28a-f show idical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Was Decedent Ever Armed Forcas? 1. Yes 2 □ No If Yes, Give Yaar or Dates: W	t in U,S. WII	If Yas,	ecedant of I specify Cub s 2 No	oan, Mexican, Puer	Specify Yas or No- rto Rican, etc.)	Black	- America c, White, e	etc.	
5-0	be filed within 72 ho ital Hygiene. Id other than "natur event, the Medical	Completed	15. Decedent's Ed (Specify only highest grad	ucation de com <i>pleted)</i>	16a	Decedent's U	f work done	during most of wo	orking	16b. Kind of Bus	siness/Indi	ustry	
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ary	should Mark	F	19a. Informant's Name/Relationship (T		198	o. Mailing Add	ress (Stree		ural Route Number		State, Zip (Code) 21	740
	s 1 end 2 should f Health and Mer fem 27 is marks other traumatic		Anna M. Swarn	er	j				Terr.,				
ore	ges 1 of He If Item or oth		20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cramation 3 ☐ I	1		of Disposition (ica)	Data	20c. Location - 0	City or Tov	vn, State	
E	nit. Pag artment ortant: I Injury c		4 Donation 5 □ Other (Specify	telliova ilolli State	Restl	awn Mer	n. Gar	rdens	7/7/98	LaVale,	MD		
Baltimore,	permit. Pages 1 end Department of Health Important: if Item 27 any injury or other tr 2005e.		21. Signature of Fanel di Slavvice tutore	KAD					Kight Fu				2150
1			23a. Part1. Enter the disaase, or comp shock, or heart failure. List only of	lications hat caused the one cause on each line.	death. Do	not enter the r	mode of dyl	ng, such as cardia	c or respiretory arm	est,	1	Approximate Interval Between	reen
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	. Dehy di	ation	n						Onset and De	
		er	rosaling in deality	Due	to (or es e	consequenca	of):	/	. / /		1	2Dp 13yes Gmon	0.40 (
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68760,	ertificate be executed ling physician end e as the bunel-transit	Medical	that initiated events resulting in deeth) Last	0		consequence	of):				1		
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ou c	Jing Ph J. After th funeral	ion:	27. Manner of Deeth 1 ☑Netural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b.	Time of Injury	28c. Inju Wo		28d. Describe ho	w Injury occurre	d		
Division	Attence or death	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, fa	M arm, street, fac]Yes 2□No	28f. Location (St City or Town	reet end Numbe n, State)	r or Rural	Route Numb	er,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	edical (29a. Certifier (Check only one) 1 Certifying Phy 2 Madical Example	sician: To the best of my fner: On the basis of exa and manner stated.	y knowledge mination an	e, death occur ad/or investigat	red at the fi	me, dete and plac opinion, deeth occ	e, and due to the courred at the time, d	ause(s) and mar ate and placa, a	ner as sta nd due fo	ited. tha cause(s)	
	withir To the	Me	29b. Signature and title of certifier				29c. Licen:	se number	2	9d. Data signed	(Month, D	iay, Yaar)	
	6		CPM		MO		D	3058	4	7/5	198		
	4.1		30. Name and address of person who co	ompleted cause of death	(Item 234)	(Type, Print)		10:	/ Agno	1	-		
	1110		haurence Green	rspoon, ml	2//	70 W	. H.	ghst.	Hand	och, 1	ud.	2175	0
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's	Signature			/		/			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ALMEDA VIRGINIA SELLERS June 30, 1998 10:23 p.m. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Memorial Hospital & Medical Center Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days Months Hours 1 M 2 ₹ F 73 Yrs. Director 218-16-3552
Usuai Residence of Decedent 2 1925 MARYLAND JAN permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, it a Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limite 1 ☐ Yes 2 ☐ No Directo MARYLAND ALLEGANY CUMBERLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11111 LOCUST GROVE ROAD N.W. 21502 U.S.A.

14. Race - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give A Yeer or Deles: 1 □ Never Married 2 □ Married WHITE altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cotlege (1-4or 5+) Eiementary/Secondary (0-12) CELANESE CORP OF AMERICA MANUF. SILK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CHRISTOPHER COLUMBUS GARLICK ETHEL NORA O'NEAL 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER 14303 WINCHESTER ROAD CUMBERLAND MARYLAND 21502 CAROLYN L. MARTZ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Buriel 2 Cremation 3 Removat from State SUNSET CEMETERY JULY 3 1998 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Sunture of Funeral Service Licen 22. Name and Address of Fecility MERRITT-ADAMS FUNERAL HOME embl 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finai 9 MONTHS ACUTE RENAL FAILURE disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner DIABETES MELLITUS 25 YEARS and I-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician at s the buriel-t Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) 80 23b. Did tobacco use contribute to the cause of deeth? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t d be detect 2 No 3 ☐ Probably 4 ☐ Unknown p 24b. Were autopsy findings available prior to completion of cause of death? should should Completed 24a. Was an autopsy certificate hes b director, page 2 s 2 No 1 Yes Division of Vital or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 XInpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) funeral 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. I Director: A 6 Could not be determined hin 24 hours efter de the Funerel Directo npletely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To the F 29d. Date signed (Month. Day, Year) 29b. Signame and may of certifier 29c. License number 5 1998 D 23371 July

625 Kent Avenue, Cumberland, MD

304Registraça Signature

21502

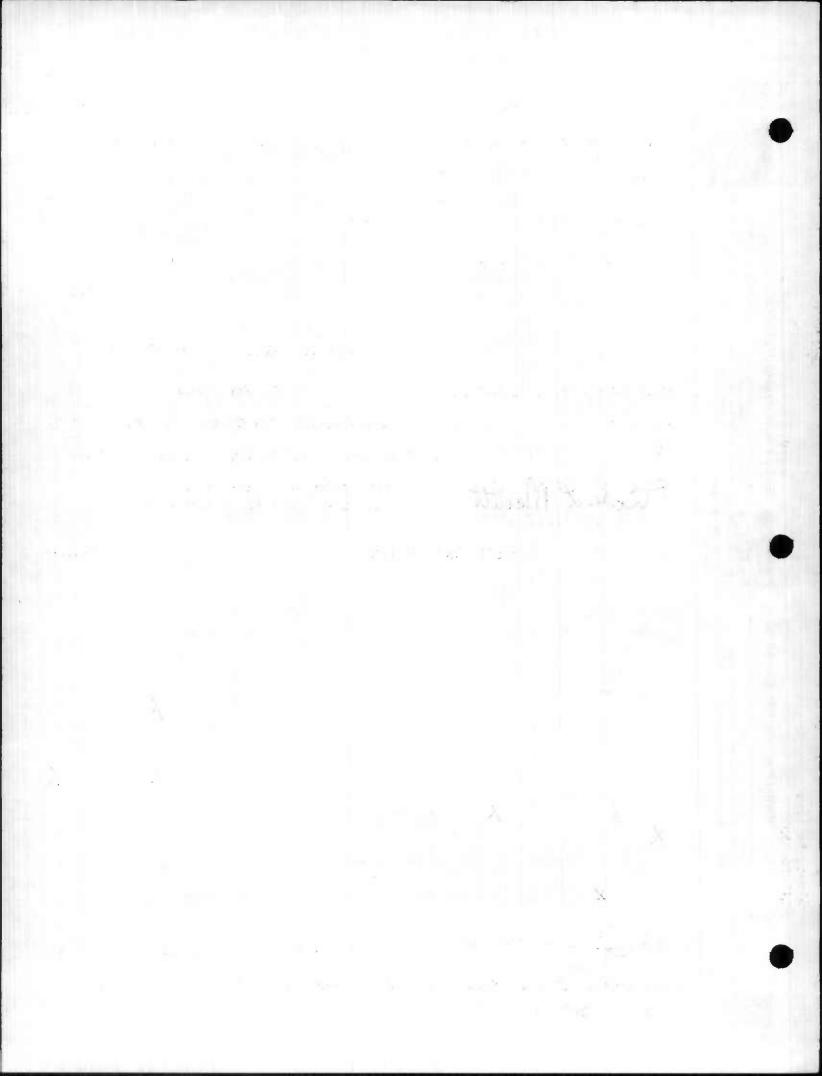
State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Qamar Zaman, M.D.,

31. Date filed (Month,

Almeda Sellers

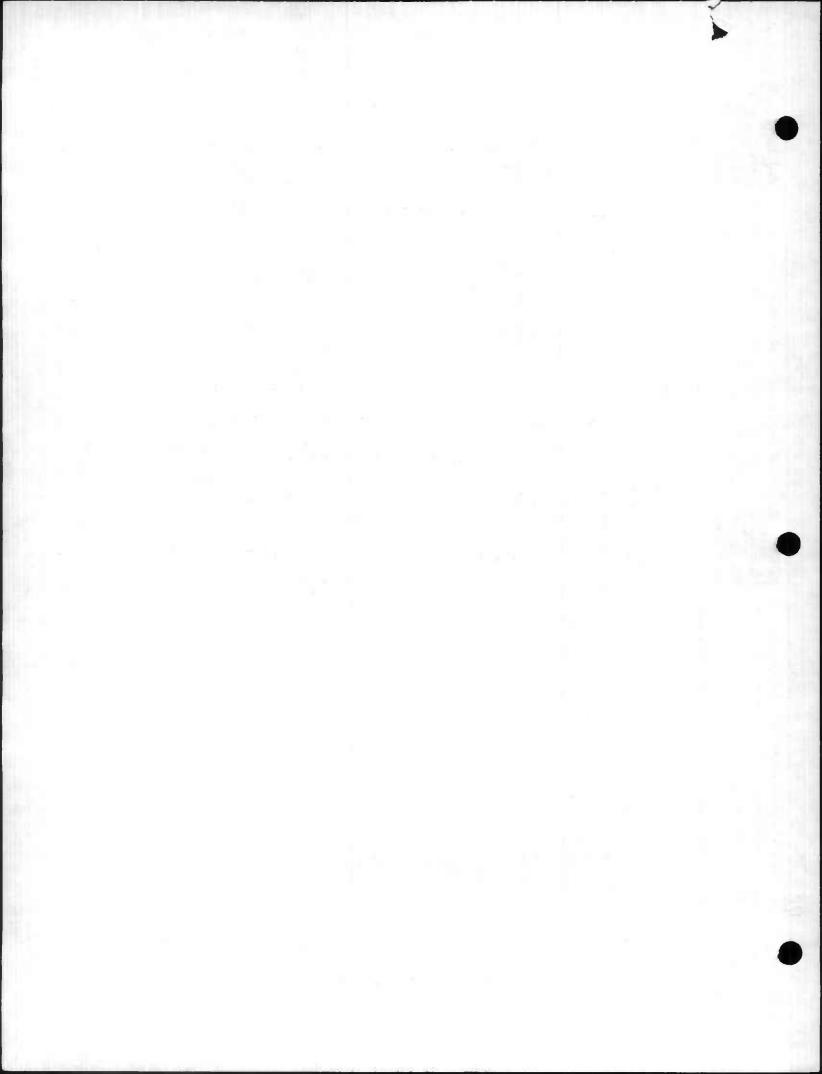
218-16-3552



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name (First Middle Lest) 2. Date of Deeth Day 1998 Year **Physician** JULY TURNER 5, JOSEPH 0510 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birtholace (State or Foreign Mary trand **Funeral** M 2□ F Months Days 579 20 6750 73 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Prince Frederick 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Moorest Examiner must be notified at Maryland Calvert Director 1 Yes 2 N 10g. Citizen of Whet Country? United States 10e. Street and Number 10f. Zip Code permit. Peges 1 end 2 should be flied within 72 hours after deeth with I Department of Health and Mental Hygiene. Important: If Itam 27 is merked other than "natural", or frems 23a or 2 any injury or other traumatic event. 85 Hospital Drive 20678 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0020 Specify: white 1 ☐ Yes 2X No Specify. by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fuel Oil Co. office Manager 8 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Dorothy Briscoe Floyd Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5637 Cherry St. St. Leonard, Md. 20685 Edna B. Turner- wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) July 6 1998
Metropolitan Funeral Service 20a. Method of Disposition Alexandria Virginia 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Service Licenses 4405 Broomes Is. Rd. Port Republic Maryland 2068\$ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** LEFTLUNG PNEUMONIA /Medical tmmediate Cause (Final diseese or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed bunei-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and HYPOTENSION Box 68760, physician Physician/Medical the Due to (or as a consequence of) Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No certificete ospital or Attanding Physician: The hours after death.

uneral Director: After this certificete ity filled in by the funeral director, pa 25. Was case referred to medical 9 26. Place of Death (Check only one) Hospital: 1 Unpatient 2 ER/Outpatlent 3 DOA 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 19ratts D-025519 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Dr. Atul Shah, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Julia Davidson Rardall JUL 06 Registrar



111 Penn Street, Baltimore, Maryland 21201

Registrar

State

IWIU

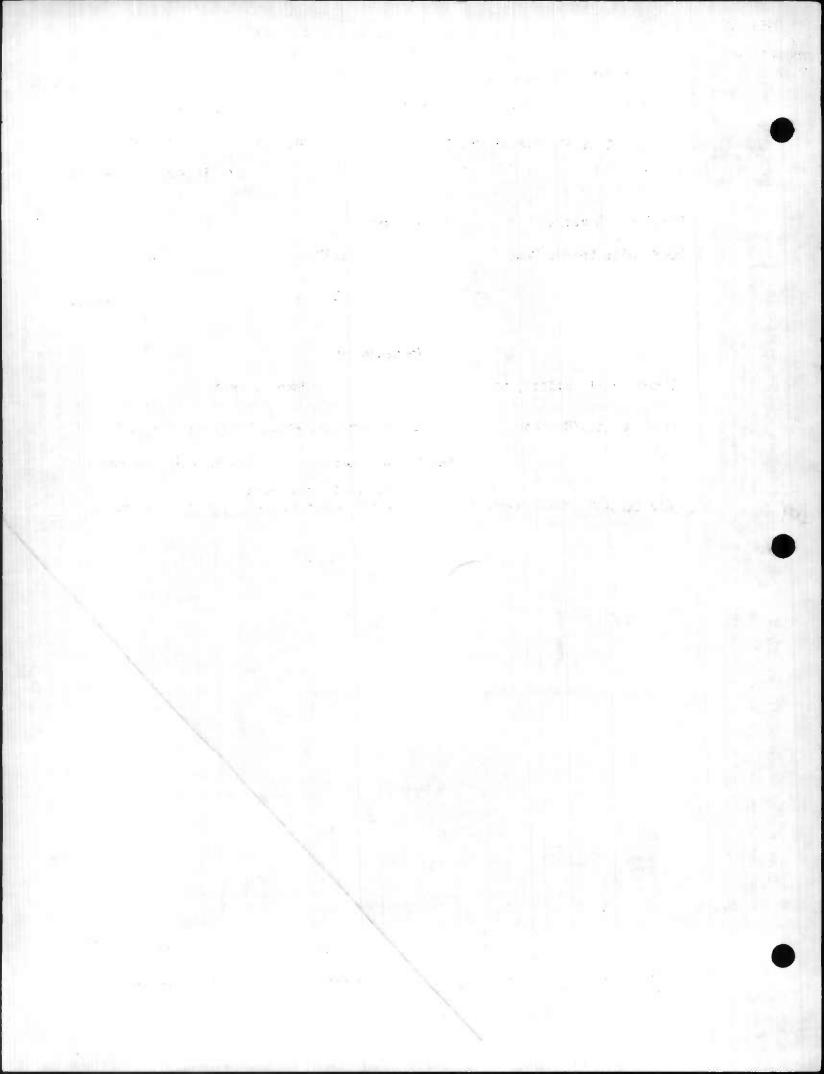
31. Date filed (Month, Day, Year)

JUL 161998

Fowler

32. Registrar's Signature

Julia Davidon



98-3515-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

BARRY	
THOOPT	

State of Maryland / Department of Health and Mental Hygiene
ITEMS: #23 PART I, 27, 28A-F PER MEO FILM Certificate of Death

Reg. No.

28d. Describe how Injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3116 E. BALTIMORE ST. BALTIMORE MARYLAND

29d. Date signed (Month, Dey, Year)

JUNE 21, 1998

UNKNOWN

111 Penn Street, Baltimore, Maryland 21201

21931

Physicia /Medica Examine

Funeral

Director

28a-f show

item 27 is marked other than "naturel", or items 23a or 28a-1 sho other treumstic event, the Medical Examines must be noured as 2 should be filed within 72 hours after and Mentel Hygiene. permit. Peges 1 end 2 Department of Health e Important: If item 27 le any Injury or other tre **Physician**

/Medical **Examiner**

Baltimore, Maryland 21215-0020

ettending physicien end for use es the burial-transit that the death certificate be execu Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director,

27. Menner of Death

1 Neturel

2 Accident

4 Homicide

29b. Signature and title of certifier

3 Suicide

29e, Certifier (Check only one)

5 Pending investigation

6 Could not be determined

	1. Decedent's Name (First, Middle, La	st)							2. Date of D				3. Ti	me of Deeth
an al	Barry Lee W	essells							JUNE		0, 19	Year 998	3:	45P.M
er	4a Fecility Neme (If not institution, git	ve street end number,)				4b. City, To	wn, or L	ocation of Dea	ath 4	c. County	of Death		
	3116 E.BALTIMORE						BALT							
		Sex 7. A	ge (In yrs. lest 38	birthdey) Yrs.	If Under 1 Months	Year Days		24 Hrs. Min.	8. Dete of B (Month, D June	Dey, Yea	960		place (Sintry)	tete or Fore and
	Usual Residence of Decedent													
	10a. State 10b. County		10c. City, To	own or Loc	cation							1		de City Limi
PO	Maryland			B	altin	001	-0						10	Yes 2□1
by Funeral Director	10e. Street and Number				10f. Zip C		. C			10a. C	itizen of V	Vhat Cour	ntry?	
ō					10									
La	3116 E. Baltim						1224				U	.S.A		
Ine	11. Meritel Status	12. Was Decedent Armed Forces	?	13. V	Vas Decede Yes, specif	nt of l	Hispanic Ori pan, Mexicar	gin? (Sp	ecify Yes or N Rican, etc.)	10-		e - Americ k, White,		9n,
F	1X Never Married 2 ☐ Married	1 Yes 2 X	No		☐ Yes 2)									
by	3 Widowed 4 Divorced	Yeer or Dates:		,	105 2	Ž1 140	эреспу.				Specify		Whi	te
pa	15. Decedent's E		11	6e. Deced	ent's Usual	Occu	pation			16b.	Kind of Bu	siness/in	duatry	
olet	(Specify only highest gr			(Give F	kind of work OO NOT use	retire	during mos	t of work	ing					
Be Completed	Etementery/Secondary (0-12)	College (1-4or	5+)	Pai	nting	C	ontra	acto	r	C	onst	ruct	tio	n
Oe	17. Father's Neme (First, Middle, Las.	t)	,				18. Mothe	er's Nam	e (First, Midd	le, Meide	en <i>Sum</i> em	10)		
To B	Not known							Ju	ne Abl	oott	:			
	19a. Informant's Name/Reletionship	(Type, Print)	1	9b. Mailin	g Address (Stree	t end Numb	er or Ru	el Route Num	ber, City	or Town,	Stete, Zip	Code)	
	Susan Gay-Sist	er		3820	Elml	67	AVE		Baltin	nore	, MI	D 21	213	
	20a. Method of Disposition		20b. Place	of Dispos	sition (Neme	of			Date	T	Location -			
	1 ☐ Burial 2 ☒ Cremation 3 [4 ☐ Donetion 5 ☐ Other (Special		ceme	etery, crem	etory or oth	er ple		nc	6-23		Balt			
	21. Signature of Funeral Servica Lice	nsee /					ess of Fecili			-				
	You E	1		C	urrar	1-I	Bromw	ell	Funer	ral	Home	e, P	. A .	
_	Willeen Burd	w scone	wel	2	08 ні	gl	st.	, C	ambrio	dge.	MD	216	13	
	23a. Pert1. Enter the disease, or conshock, or heart failure. List only	nplications that cause y one cause on each l	d the deeth. Dine.	Do not ente	er the mode	of dy	ing, such as	cardiac	or respiretory	errest,		1	Appro	el Between
	Dec 2											i	Onset	and Death
	Immediete Cause (Final	NARCOTT	C AND CO	CATHE	AND ALC	OHO	THITOV	TCATE	ON			1		
	diseese or condition resulting in death)	a				JOHN	LINIUX	ICATI	UN			1		
e			Due to (or es	e consequ	uence or):							ŀ		
n-		b										1		
хал	Sequentially list conditions, if any, leading to immediate		Due to (or as	a consequ	uenca of):							i		
H	cause. Enter Underlying Cause (Disease or Injury													
ca	that initiated events resulting in death) Lest	С	Due to (or as	a consequ	uenca of):									
8	resulting in death) Lest											-		
3		d												
cla									1					
ysi	Part II. Other significant conditions	contributing to death I	but not resultin	g in the un	iderlying car	use g	iven in Part	l.						uss of dea
P									1[Yes	2 10 No	3 Pro	bebly	4 Unkno
Completed by Physician/Medical Examiner														
B									24e. We	es en au	topsy	24b. W	ere auto	opsy finding prior to
let												CC		n of cause
THE										No.	•□		. /	a 🗆 🕶
ပိ									10	Yes	2 No	11	Yes	2□ No
Be	25. Was case referred to medical examiner?					1 -		e of Dee	th (Check only	y one)	-			
2	Yes 2□ No	Hospitel: 1 ☐ Inpati	ient 2 ER	/Outpatien	t 3 DOA	10	ther: 4□ Ni	ursing H	ome 5 Re	sidenca	8 DOth	er (Specia	fy)	

State Registrar

Certification:

Medicai

32. Registrants Signature

28b. Time of P

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND: RESIDENCE

FOUND3:30M

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

**Common Physician: To the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

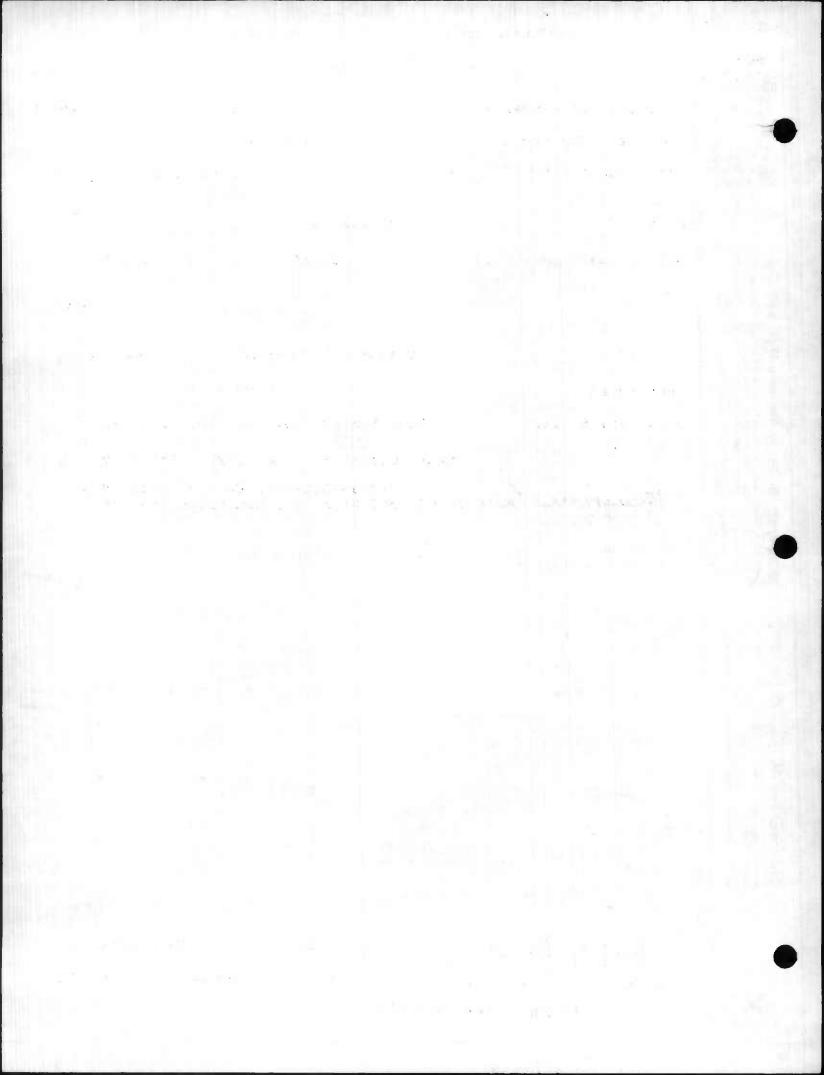
O.C.M.E.

1 ☐ Yes 2 No

28a. Date of Injury (Month, Dey Year)

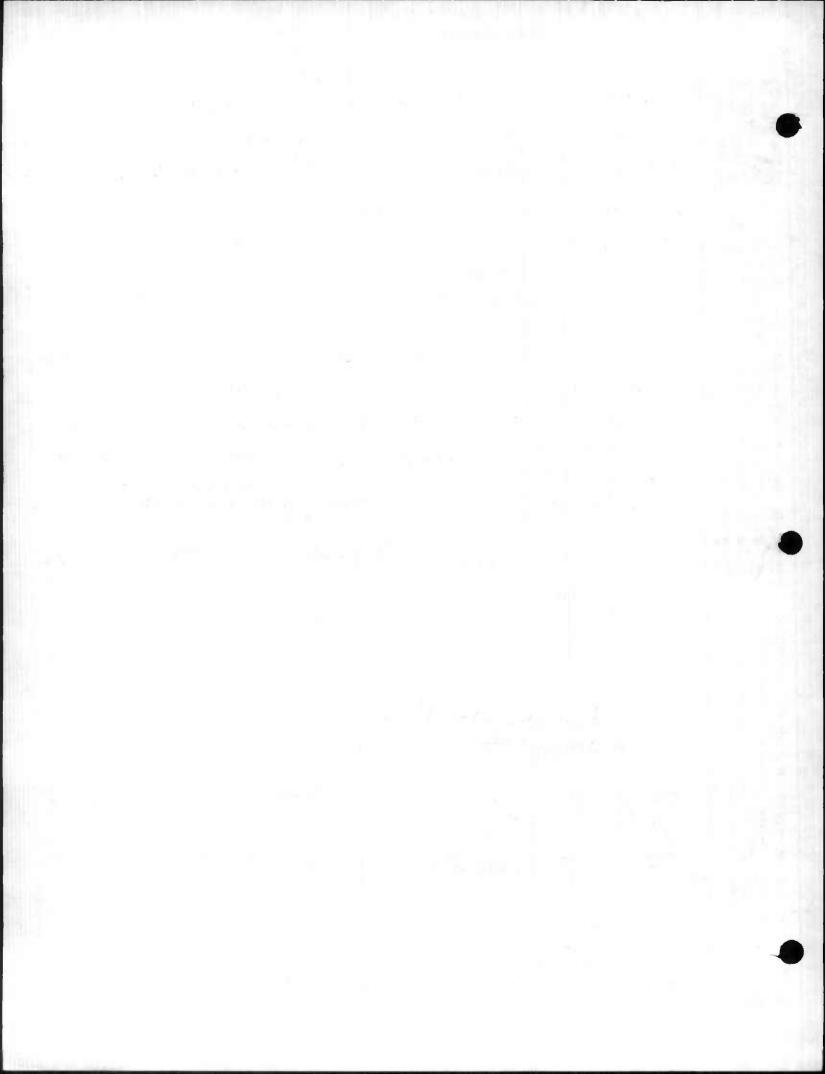
FOUND 6-20-98

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene

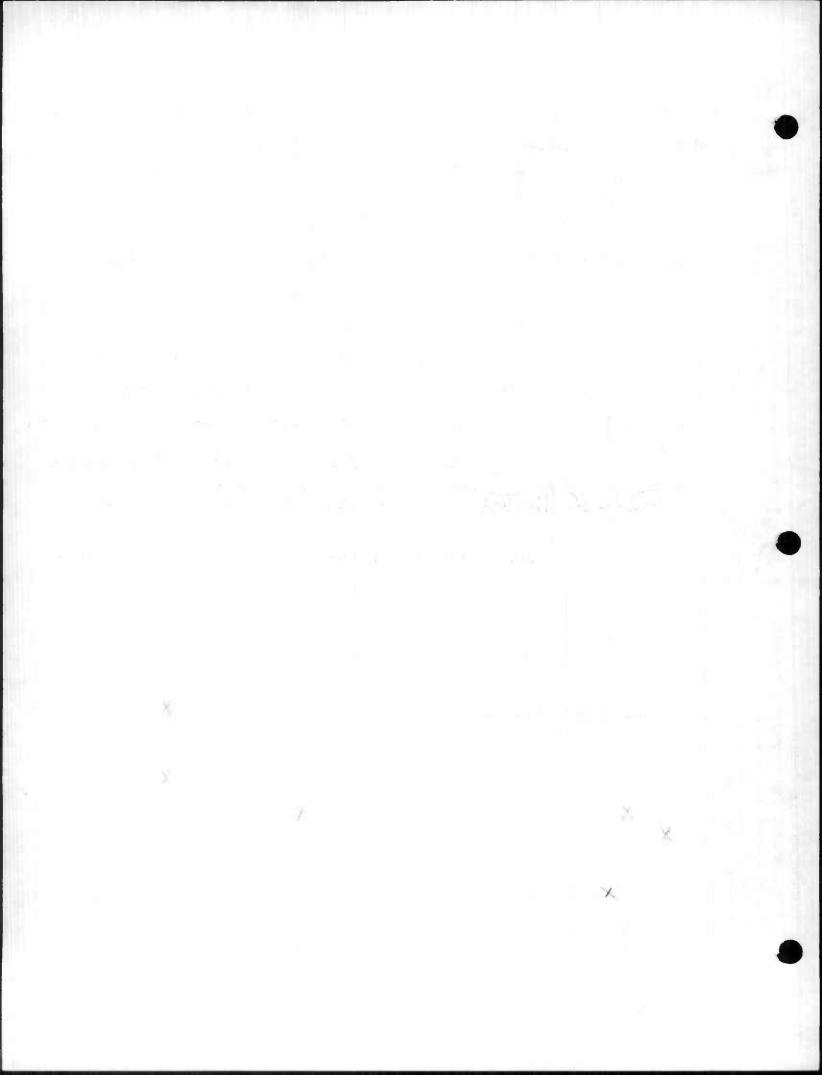
			Decedent's Nama (First, Middle, Last))	Certific	ate of Death	2. Date of Dea	leg. No.	8 2 932
	Physici		ROBERT	DICE	WEST	SR.	Month	5, 1998	Year
	/Medic Examir	-	4e. Facility Name (If not institution, give Calvert Memori			4b. City, Town, o	or Location of Death	4c. County	of Death
	Funeral Director		5. Social Security Number 6. Security Number 1578 09 4520	7. Age (In yrs.	last birthdey) If Un Yrs. Month	der 1 Year If Under 24 H		12 1922	9. Birthpiace (State or Foreign Country) Washington DC
Maryland	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Calvert	10c. Cit Por	y, Town or Location t Republi	С	-		10d, inside City Limits 1 ☐ Yes 2 No
with th	3a or 28 at be no	al Director	327 Howard Drive)	10f.	Zip Code 20676		10g. Citizen of V United	What Country? States
020 ours after deat	el', or itams 23a or 28a-f show Examinet nast be nullfied at	by Funeral	11. Marital Status 1 Naver Married 2 Married 3 Widowed 4 Divorcad	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: WWII	4 T V-	cedent of Hispanic Origin? pecify Cuban, Mexican, Pur 2 2 No Specify:	(Specify Yes or No- erto Rican, etc.)		e - American Indian, k, White, etc. white
d 21215-0020 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. impurial, or important: if Item 27 is marked other than "natural, or any injury or other traumatic event, the Medical Examples.	Completed	15. Decedent's Edu (Specify only highest grade Elemantary/Sacondary (0-12) 12	cation e <i>completed)</i> Collega (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO:			16b. Kind of Bu	t. of Defense
Maryland d2 should be file	and Mental H is marked off aumatic ever	To Be	17. Father's Name (First, Middle, Last) Harry W. West				ame (First, Middle, Lainhart	Maidan Sumām	Θ)
Mar	h and 7 is m traum		19a. informant's Name/Ralationship (Ty S. Jean West- wif			ass (Street and Number or			
a, =	Health tsm 27 other tr	H	20e. Method of Disposition	20b. P	lace of Disposition //	ard Drive Por	-	-	Land 20676 City or Town, State
Baltimore,	Department of I important: if its any injury or of once.		1 Burial 2 Fremetion 3 R 4 Donation 5 Other (Specify)	Met	ropolitan	Funeral Serv			ia Virginia
Bal Pemii	Depar impor any in		21. Signature of Funeral Sarvice Licanse	300		and Address of Fecility	Rausch I		Home PA Maryland 2067
Bouted	nysician Medical Medical as the privet-transit	ai Examiner	immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events)	TE M or as a consequence of		OC IN	Parc	TIDIN IWIL
Box 68760, ath certificete be av	ettending physic for use as the	Ped	that initiated events resulting in deeth) Lest		r as e consequenca o	ŋ:			
P.O.	been signed by the e should be datached f	y Physician/	Part ii. Other significant conditione con	tributing to death but not rask	ulting in the undarlyin	g cause given in Part i.			atribute to the cause of death? 3 Probably 4 Unknown
Vital Records, P.O. Box sician: The law requires that the death cer	s been sign 2 should be	Completed by	DIAB	nous Ceil			24a. Was a perfor		24b. Were autopsy findings available prior to completion of cause of death?
F 18	ate has page 2	Com					1 🗆 Y	as 2 No	1 ☐ Yes 2 ☐ No
of Vita Physician:	is certificate director, pag	Be	25. Was case refarred to medical axaminer?	lospitai:		Othor	eath (Check only or		
o g	rai d	tion: To	1 Yas 2 No 27. Manper of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of injury (Month, Day Year)	ER/Outpatient 3 D 28b. Time of injury M	28c. injury at Work? 1 Yes 2 No	Home 5 Reside		
Division To the Hospital or Attending	within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Placa of injury - At ho building, etc. (Specify	ome, farm, street, fact	ory, office	28f. Location (S City or Town		er or Rural Route Number,
ospit	24 hour Funera letaly fills	edical	29a. Certifier Check only one) Cartifying Phys	ician: To the best of my knowner: On the basis of axaminat and manner stated.	wledge, daath occurre tion and/or investigati	ed at the time, date end pla on, in my opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and ma ate end piece, e	nner as stated. and due to the ceuse(s)
I	S Z Q	Me	29b. Signature end title of codifier		1	29c. License number	2	9d. Date signed	Month One Vand
1 Potto	Tot	-							(Month, Dey, Year)
BE	10 To the					02965	7	7/6/9	(Month, Dey, Year)
BE	Tou		30. Nama and address of person who co				7	7/6/9	(Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_				State of Mary		rtificate of			Reg. No.	3 2	1933	
	Physici	an	Decedent's Neme (First, Middle, Last)					2. Date of De Month	eth Dev	Year	3. Time of Death	
	/Medi		EDNA ELIZABETH	WILSON				July 3,			6:15A,M.	
	Examir	ner	4e. Facility Neme (If not institution, give st.	reet end number)			4b. City, Town, or I	Location of Death	4c. County	of Deeth		
			DEVLIN MANOR NURSI				CUMBERLAN			EGANY		
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. lest birthday) 7 Yrs.	If Under 1 Year Months Deys		8. Date of Bir (Month, De	th y, Year)	9. Birthple Country	ce (Stete or Foreign	
	Director		213-40-2832 Usual Residence of Decedent	NEXT O	/ 113.			APRIL 4	1911		PA.	
	land the		10a. State 10b. County	100	c. City, Town or Lo	cation		-		100	d. Inside City Limits	
	the Marylar 28s-f show	ţ	MARYLAND ALLEGAN	Y	CUMBER	RLAND					1 ☐ Yes 2 No	
	r 28s	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country	y?	
	23a or	5	11501 FAIRVIEW ROAD	n s F		215	502		II	S.A.		
	items 2	ner		. Was Decedent Ever	in U,S. 13. V		Hispanic Orlgin? (S an, Mexican, Puert	pecify Yes or No		e - American	Indian,	
21215-0020	क ठे	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:		f Yes, specify Cub	an, Mexican, Puert Specify:	o Rican, etc.)	Specify	k, White, etc. WHIT		
5-0	72 hours netural;	Completed	15. Decedent's Educa (Specify only highest grade of	tion	16a. Deced	dent's Usual Occup	pation during most of wor	tina	16b. Kind of Bu	ısiness/îndu	stry	
21	d within 72 ho plene. r than *netur the Medical	npie	Elementery/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	d)	Knig				
2	filed with Hyglene. ther than		4		HOUSE	KEEPER				KEEP	ER	
and	be filed stal Hyg of other event,	Be	17. Father's Neme (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Meiden Sumem	e)		
K	12 should be filed a end Mental Hygin is marked other raumatic event,	To		MERICK		_			ETH DEVO			
Maryland			19e. Informent's Name/Reletionship (Type: JAMES FREDERICK WI				end Number or Ru				ŕ	
o o	Health em 27		20a. Method of Disposition		Ob. Place of Dispo	sition (Neme of	T	Date Date	20c. Location -		AND 21502	
no	Pages nent of in nrt: If its iry or o		1 X Burial 2 ☐ Cremetlon 3 ☐ Rei			netory or other ple						
Baltimore,	artme ortani		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Ю. Н	ILLCREST	CEMETERS Name and Addre		7 1998 (CUMBERLA	ND MA	RYLAND	
Ba	permit. Pages 1 end 2. Department of Health er important: if item 27 ia any injury or other trau		A LUM	OH-			DAMS FUNE	RAL HOM	Ε			
			23a. Part L. Enter the diseese, or contrict	ettions that caused the	death. Do not ente	04_DECATI	JR STREET	CUMBERI	LAND MAR		Approximate	
	Physician	2 1	23a. Part . Enter the diseese, or complice shock, or heart failure. List only one	cause on each line.		or allo mode or ay	ng, out a out a co	or respiretory a		lr Ir	ntervel Between Onset end Deeth	
	/Medical		Immediate Cause (Finel							i.		
	Examiner		disease or condition resulting in death)	Acute cere	to (or as e conseq		dent			11	month	
	p #	iner		7.50	(0.000	,=0.100 01,7				- 1		
	the death certificate be executed y the ettending physician and ached for use as the bunal-transit	Examiner	Sequentielly list conditions,	Due	to (or es e conseq	uence ol):						
00	e execution a		Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							1		
68760,	cate t	edicai	that initiated events resulting in death) Last	Due	to (or as a consequ	uence of):						
	ding p		d.							1		
Box	eath cert ettending	Physician/M										
o.	that the de	ysi	Part il. Other significant conditiona contri	buting to death but no	resulting In the un	nderlying cause gi	ven in Part I.	23b. Did	W	ntribute to t	he cause of death?	
0	that ed b		Coronary artery di	sease.				10	Yes No	3 Proba	bly 4 Unknown	
Records,	requires i	d by						24a. Was	en eutopsy	24b. Were	e autopsy findings	
00		Completed							med?	comp	able prior to pletion of cause leth?	
Re	The law ate has b page 2 s	E						1 □ Yes 2 M				
Vital	ician: The	BeC	25. Was case reterred to medical				26. Piece of Dee			10	1 ☐ Yes 2 ☐ No	
\geq		To B	examiner? * *	spital:	2 ER/Outpetien	t 3 DOA Oti			dence 6 Othe	er (Specify)		
Jou	g Physer this		27. Manner of Death	28e. Date of Injury (Month, Dey Yea	28b. Time of	28c. Inju Wo			now injury occurr			
10	Attending or death. actor: After by the fune	atio	1 Natural 5 Pending 2 Accident Investigation	(Motur, Dey 16a	(r) Injury		Yes 2 □ No					
Division	il or Attend efter death Director: / d in by the f	Certification:	3 Sulcide 6 Could not be 4 Homicide determined	eet, factory, office		Street end Number or Rurel Route Number, wn, Stete)						
0	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer			building, etc. (Sp								
	Hospital 24 hours e Funeral Celeby filled	edicai	(Check only 2 Medical Examine	lan: To the best of my r: On the basis of exar and manner stated.	knowledge, death nination and/or inv	occurred et the ti restigation, in my d	me, dete end plece opinion, death occu	, end due to the rred et the time,	cause(s) and ma dete and plece, a	nner as stet and due to th	ed. ne cause(s)	
	within 2 To the Complet	Med	29b. Signeture en Mitter of certifier	se number		29d. Date signed						
			1.11	-			280		1			
-	2	-	30 Name and address of the	delend or the state of the state of	(11		200		July	1117	14	
(MIS		30. Name and address of person who com									
	Sta	te	DR SUNIL K. GUPTA 31. Date filed (Month, Day, Yeer)	625 KENT	AVE . CI	UMBERLAN	D MARYLAN	D 2150	02			
	Domina		"1111 D & 1000	AN ASSESSMENT OF THE PARTY OF T	Cont.							

EDNA WILSON 213-40-2832



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TO BE COMPLETED BY FUNERAL DIRECTOR		BY PHYSICIAN: MEDICAL CERTIFICATION	ICAL CE	CIAN: MED	HYSI
s marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	nt, the medical	or other traumatic ever	any injury.	ет 23 shows :	, or Ite
After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	etely filled in by the emation, or remova	After this certificate has been signed by the attending physician and completely filled in by the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ed by the atte	te has been signe te Dept, of Healtl	the Star
DING PHYSICIAN: The law requires that the death certificate be executed writin or hours after death. Page 6 may be retained by the hospital or attending physician.	thin 24 hours after	n certificate be executed wi	that the deat	The law requires	SICIAN

		1 - STATE OF MARYLAND / DEPARTMENT OF HEAR CERTIFICATE OF D	
		1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH
		IRA T. WATKINS 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) at under 1 year 1 and	F UNDER 24 HRS. 7, DATE OF BIRTH 8, BIRTHPLACE (State or Formion
pino		217-10-6256 1 X M 2 - F 92 YRS. MONTHS DAYS H	F UNDER 24 HRS. 17. DATE OF BIRTH (Morth, Dey, Year) OCT 25,1905 ALABAMA LOCATION OF DEATH 9c. COUNTY OF DEATH
1, 2, 3 should	ECTOR		
permit. Pages	DIREC	100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION CUMBERLAND	LIMITS?
it perm	RAL	100. STREET AND NUMBER 101. ZI	P CODE 10g. CITIZEN OF WHAT COUNTRY?
020 physician, burial-transit	FUNERAL	701 FURNACE ST., WILLOW VALLEY APT331 2 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEN	21502 USA DENT OF HISPANIC ORIGIN? (Specify Yea or No — 114. RACE — American Indian.
9 8 4	B	3 ★ Widowed 4 □ Divorced IF YES, GIVE WAR OR DATES 1 □ YES 2	by Cuben, Maxicen, Puerto Rican, etc.) No Specify: Black, White, etc. Specify WHITE
- 5 3	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	16b. KIND OF BUSINESS/INDUSTRY
O to	MPL S	6 AUTO MECHANIC	AUTOMOBILE
d 5 9	400	TITTTTAN TIAMETERS	8. MOTHER'S NAME (First, Middle, Melden Surneme)
MARY retained to 5 should	2 0	100 INFORMANT'S MAME (Troffice)	ARY KATHERINE BIELETZ Number or Rural Route Number, City or Town, State, Zip Code)
		ALPHIA SHARPLESS 1832 FROSTBU	RG RD, FROSTBURG, MD 21532
BALTIMORE, I ter death. Page 6 may be the funeral director, page wal.	must be	20s. METHOD OF DISPOSITION 1 M Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name cametery, crematory or other piece)	THILY
	mer m	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND	ERY 5 1998 MEYERSDALE, PA
ALT death.	mexa		CHAPEL OF THE HILLSMORTUARY
B after s after by the removal	medicai examiner	23. PART I. Enter the discusse, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	
within 24 Pipetery file	event, the me	immediate cause (Final disease or condition resulting in death) Due to (or as a consequence of):	interval Batween Onset and Dasth G-mall
P.O. BOX 687(th certificate be executed anding physician and com Hygiene prior to burial,	or other traumatic	resulting in death) LAST	
Me We	Injury.		ausa givan in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS
COR signed by Health an	shows any MEDICA		PERFORMED? 1 YES 2 X NO AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! 1 YES 2 NO
L law	23 sh		
上 F and	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpettent 2 ER/Outpatient 3 DOA 4 Propriet	E OF DEATH (Check only one)
OF V PHYSICIA this certif	PHY	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK.	
0 5 4 5	ED S	2 Accident Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office 4 Homicide determined building, atc. (Specify)	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)
DIVISI TAL DR ATTEN RAL DIRECTOR: 72 hours after	ANT: If Item 2 COMPLET	29a. CERTIFIER (Check only 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and	
HOSPITAL FUNERAL Within 72	CO	II 28h SIGNATURE AND 35TV PLOE CURTICIES	9c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)
TO THE HOSPITAL TO THE FUNERAL De filed within 72 h	TO BE	Indefine	1)33280 Duly 2, 1598
7	F	STATE AND ADDRESS OF DEATH (TEM 21) (Appe, Print)	
MI		DR. SUNIL K. GUPTA, 625 KENT AVE., CUMBE 31. DATE FILED (Month Dec. 1964) 132. REGISTRAR'S SIGNATURE	RLAND, MD 21502
		31. DATE FILED (Month, Day, 1687) 32. REGISTRAR'S SIGNATURE	

Please Type or Print In Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day Vaar 3, Elsie Marie Winters 1998 July 7:30 PM 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 19012 Legislative Road Barton Allegany If Under 24 Hrs. Hours Min. If Undar 1 Year 5. Social Security Number Data of Birth (Month, Day, Year) 7-22-10 Birthpiace (State or Foraign Country) 7. Age (In yrs. last birthday) Months Days 1 □ M 2 1 F 87 216-09-7637 Yrs West Virginia Usual Residence of Decadent 10b. County 10c. City, Town or Location 10d. Insida City Limits Allegany 1-Yas 2 No Barton 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 19012 Legislative Road 21521 United States 12. Was Dacedant Evar in U,S. Armed Forces? 14. Race - American Indian, Black, White, atc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yas 2X No If Yes, Giva Yaar or Datas: 1 Nevar Married Marriad 1 ☐ Yas 20 No Specify White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Laborer Westvaco 17. Father'a Name (First, Middla, Last) 18. Mothar'a Nama (First, Middla, Maiden Sumama) Thomas Wilson Wilson Rebecca 19a. informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Roy L. Winters / Husband 19012 Legislative Road Barton, MD 21521 20b. Placa of Disposition (Name of cemetary, crematory or othar place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 ☑Buriai 2 ☐ Cremation 3 ☐ Ramovai from Stata Rocky Gap 4 ☐ Donation 5 ☐ Other (Specify) Md. Veterans Cemetery 7/6/98 Flintstone, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 111 Church St. Boal Funeral Home Westernport, MD 21562 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disea Approximate interval Between Onset and Death immediata Causa (Final diseesa or condition rasulting in daath) o (or as a consaquenca of) Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disaase or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) Dua to (as a consequence of) Part ii. Other significant conditions contributing to death but not rasuiting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yas MI No 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical examinar? 28. Piaca of Death (Check only one) examinar? Hospitel Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Inpatient 2 PER/Outpatient 3□ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

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"naturel", or items 23s or 28s-f show

other than

Hyglene

Pages 1 and 2 should be nent of Health and Mental Is marked

Health item 27

Department of Important: If its any Injury or o once.

traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death with the Manyland

Saltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records,

and attending physician for use as the buria the signed by certificate has funeral Certification:

Physician/Medical Examiner þ Completed Be 70 27. Mannar of Death

Medical

The law requires that the death certificate be axecuted To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica the filled in by

State

31. Data filed (Month, Day, Yaar) 081998 Registrar

2 Accidant

4 ☐ Homicide

(Check only one 29b. Signature

3 Suicide

29a. Cartifier

28a. Date of injury (Month, Day Year)

28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28c. injury at Work?

To certifying Physician: To tha best of my knowledge, daath occurred at the tima, data and place, and due to tha cause(s) and mannar as stated.

1 □ Yas 2 □ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

28d. Describe how injury occurred

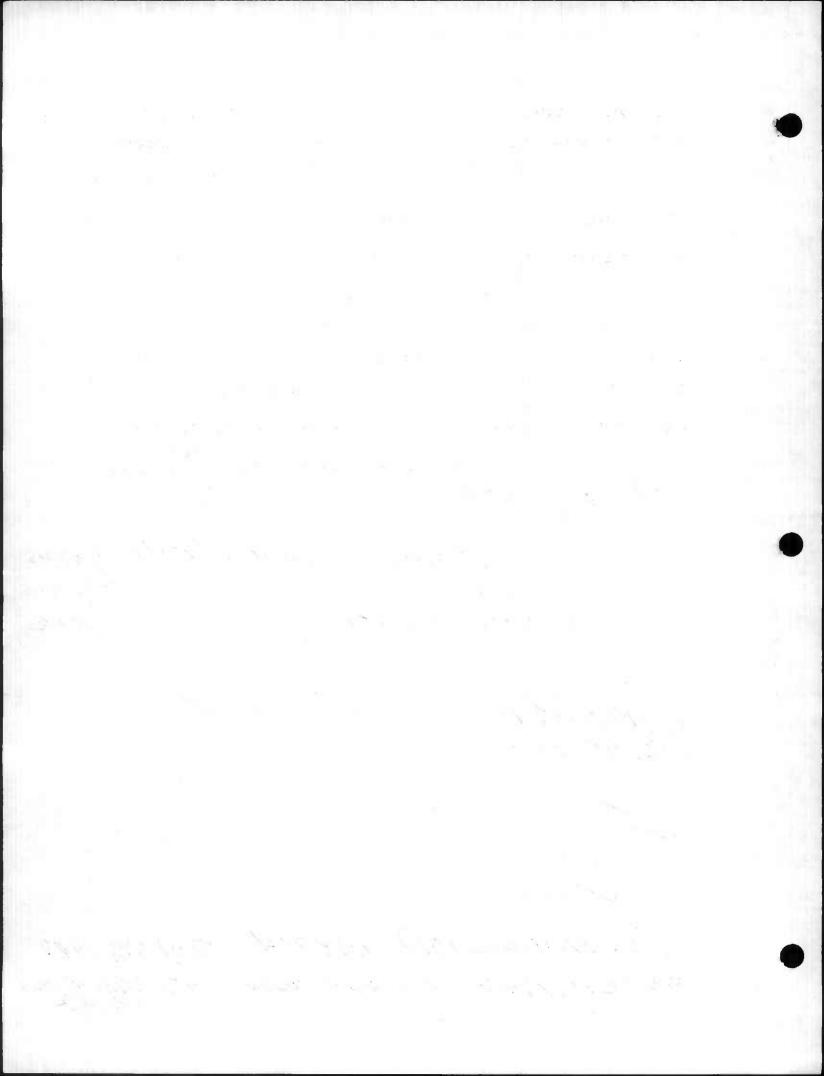
me and oddress of person who completed cause of death (Itam 23a) (Type, Print) TEMONIAL

32. Registrar's Signetura

5 Pending invastigation

6 ☐ Could not be

DHMH 16 Rev 6/95



Amended # 5, No. S. Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

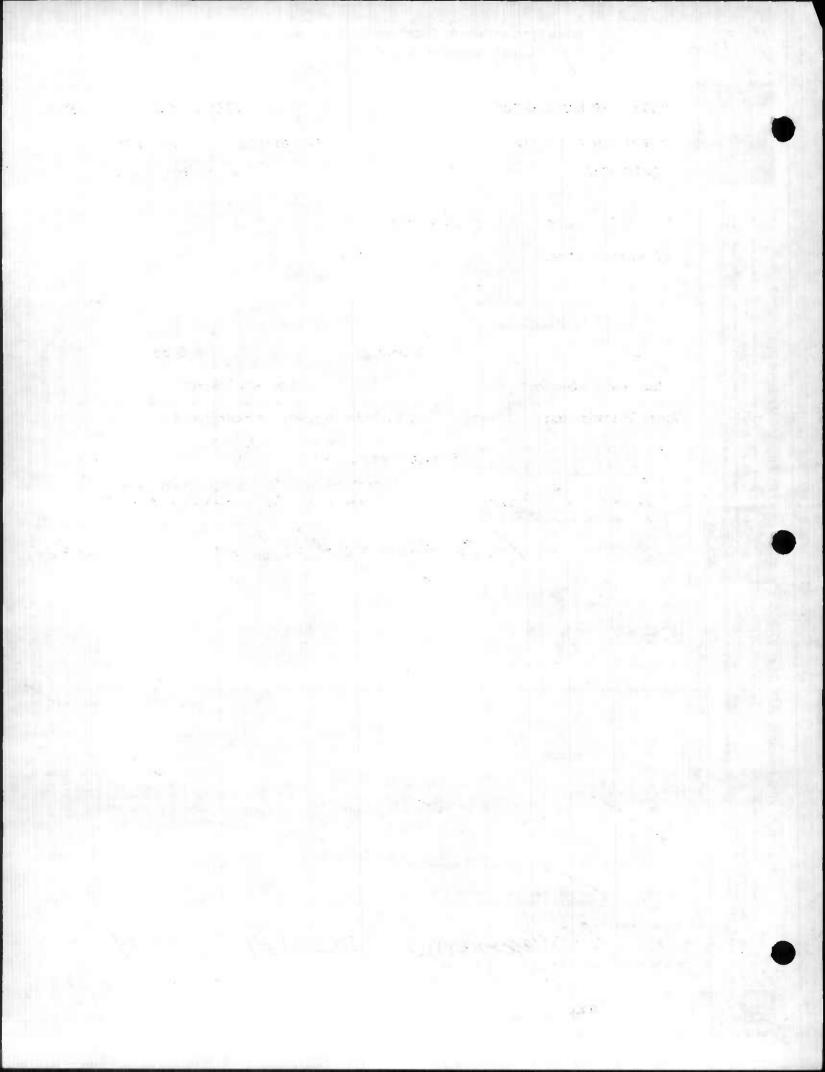
1/7/98, # Megany County State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Year **Physician** BETTY JANE WHITTINGTON JULY 2,1998 3:35PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Sacred Heart Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1 □ M 280 F Months Deys 75 Director May 16 1923 MD Usual Residence of Decedent the Maryland 10a. Stete 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10b. County Yes 2□No Directo MD Allegany Lonaconing 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 42 W. Main Street 21539 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Stetus Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiena.
nt: if Nem 27 is marked other than "natural", or Ne ☐ Yes 2 X No f Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: p 3 ₩ Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiena. College (1-4or 5+) 10 0 Homemaker Home 7 is marked other traumatic event, in 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hugh C. Fazenbaker Elizabeth McKenty 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Steve Whittington 40 W. Main Street, Lonaconing, MD 21539 son If hem 27 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition July 6. 20c. Location - City or Town, State Burlel 2 Cremetion 3 Removal from Stete permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 1998 Cumberland, MD 21. Signate 22. Name and Address of Fecility re of Funeral Service Licenses Eichhorn-McKenzie Funeral Home P.A. 8 E. Main Street, Lonaconing, MD 21539

ase, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

a. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of) attending for use as signed by the all Pert II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records. by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? should should Completed cartificata has t 1 Yes 2 WNo 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartification pletely filled in by the funeral director, Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Menney of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 1 Naturel 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homloide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of sartilly 3ple 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) nes Cumberland, Md. 21502 Bushop Walsh Dr. WAgoner MD 31. Date filed (Month, Day, Year) 32. Registrer's Signature State 0 7 1998 Registrar **DHMH 16 Rev 6/95**



3. TIME OF DEATH

4:38 PM

10d. INSIDE CITY

Specify WHITE

20651

Approximate

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

1 ☐ YES 2 ☐ NO

OF DEATH?

29d. DATE SIGNED (Month, Day, Year)

> gru

21502

29c. LICENSE NUMBER 19

CUMBERLAND MARYLAND

Interval Between

Onset and Death

3 months

1 TYES 2 NO

YEAR

REG. NO

FOR STATE REGISTRAR

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	POTATION ATTENDING DUNCTORN. The last state that doubt confident to
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH PAULINE GRACE WALLIS JUNE 1998 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 - M 2 XXF DAYS (Month, Day, Year) 214-74-5371 NOV 1905 MARYLAND use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ALLEGANY CO NURSING HOME CUMBERLAND ALLEGANY RESIDENCE OF DECEDEN 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND ALLEGANY CUMBERLAND FUNERAL 10s. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 751 FAYETTE STREET 21502 Zerhours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detachad to removal. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Merried 2 Married 1 YES 2 NO Specify: BY 3 XWidowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g Elementary/Secondary (0-12) College (1-4 or 5+) 12 +HOUSE KEEPER HOUSE KEEPER 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumame) Ħ ROBERT C. WILSON LILLIE STOTLER BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 MARY KING SLEEMAN 813 BALTIMORE ROAD ROCKVILLE, MARYLAND SISTER be 20e. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 X Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) OLIVET CEMETERY JULY 3 1998 FREDERICK, MARYLAND examiner 21. SJONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME ol 404 DECATUR STREET CUMBERLAND MARYLAND medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiec or respiretory arrest, ahock, or heert fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel cremation, #e disease or condition touline completely 0 event, 1 resulting in death) AS A CONSCOUENCE OF): and com o burial, renal TI traumatic 0 CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) prior to If any, leading to immediate cause. Enter UNDERLYING signed by the attending physician Health and Mental Hygiene prior to other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initieted events reaulting in deeth) LAST 10 any Injury. PART II. Other significent conditions contributing to direct but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL multi nema ma 1 YES 2 NO Shows demenths t. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO X PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO llem. 26. PLACE OF DEATN (Check only one certificate h HOSPITAL:
1 | Inpetient 2 | ER/Oulpetient 3 | DOA OTHER:
| Nursing Name 5 Residence 8 Other (Specify) 10 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED this marked, 1 X Natural 5 Pending 1 YES 2 ND After the BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suictde COMPLETED 8 Could not be DIRECTOR: / 4 Nomicide determined 28 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end manner as stated. THE HOSPITAL (
THE FUNERAL (
filed within 72 h (Check only one) = TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

BE

2

29b. SIGNATURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF V.A.

31. DATE FILED (Month, Day, Year)

awith

RANJITHAN

a

RSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE desitor

517 OLDTOWN ROAD

998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Defe of Deeth 3. Time of Deeth Month Dey **Physician** 1:53 PM Gabriel Arroyo July 1998 15 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner University of Maryland Medical Center Baltimore 8. Dete of Birth (Month, Dey, Year)
July 16, 1958 Kansas 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer | If Under 24 Hrs. 6 Sex Birthplece (State or Foreign Country) **Funeral** M 2□ F Months Deys Hours Min 582-08-0782 41 Director Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Heelth and Mentel Hygiene.

ant: If item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumatic event, the Medical Examinal prunt be notified at 10e Stete 10b County 10c. City. Town or Location 10d. Inside City Limits No 2□ No Director Puerto Rico Bayamon 10e. Streef end Number 10f. Zip Code 10g. Citizen of Whet Country? 36 M 8 Vista Bella 00956 United States Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Reca - American Indien, 11. Marifel Stetus Bleck, White, etc. 1 ☐ Yes 2 ☒ No No 1 Never Merried Married Specify: Puerto Rican Specify: White Yes 2 No Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Merchant-Owner Retail 18 Mother's Name (First, Middle, Meiden Surname) 17. Father's Neme (First, Middle, Last) Be Gabriel Arroyo Asuncion Marzan 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Maria L. Rivera/Wife 36 M 8 Vista Bella Bayamon, Puerto Rico 00956 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town. Stete Burial 2 Cremetion 3 Removel from Stete permit. Pege Department of Important: If any Injury or pace. Porta Coeli Cemetery 7/19/98 Bayamon, Puerto Rico 21. Signal e of Funerel Service Llo 22. Neme and Address of Fecility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Road Bowie, MD 20715 Part1 Enter the disease, or coshock, or heart feilure. List or col plicetions that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final dise or condition resulting In death) /Medical Pulmonary Hypertension Primary Examiner Examiner diseuse Coronary ortery attending physician and for use es the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Right Division of Vital Records, P.O. Box 68760, heart failure Physician/Medical Due to (or es e consequenca of) the 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? is certificate hes director, page 2 1 Yes 2 No 1 Yes 2 TNo Hospital or Attanding Physician: 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2₽-No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. Director: / 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in edical 1 Decrifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner stated. 29e. Certifier 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. License number July 15, 1998 P10224 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) UMMS 10 S. Freene St Baltimore, MD 21201 Stoller Elizabeth mp

32. Registrer's Signature

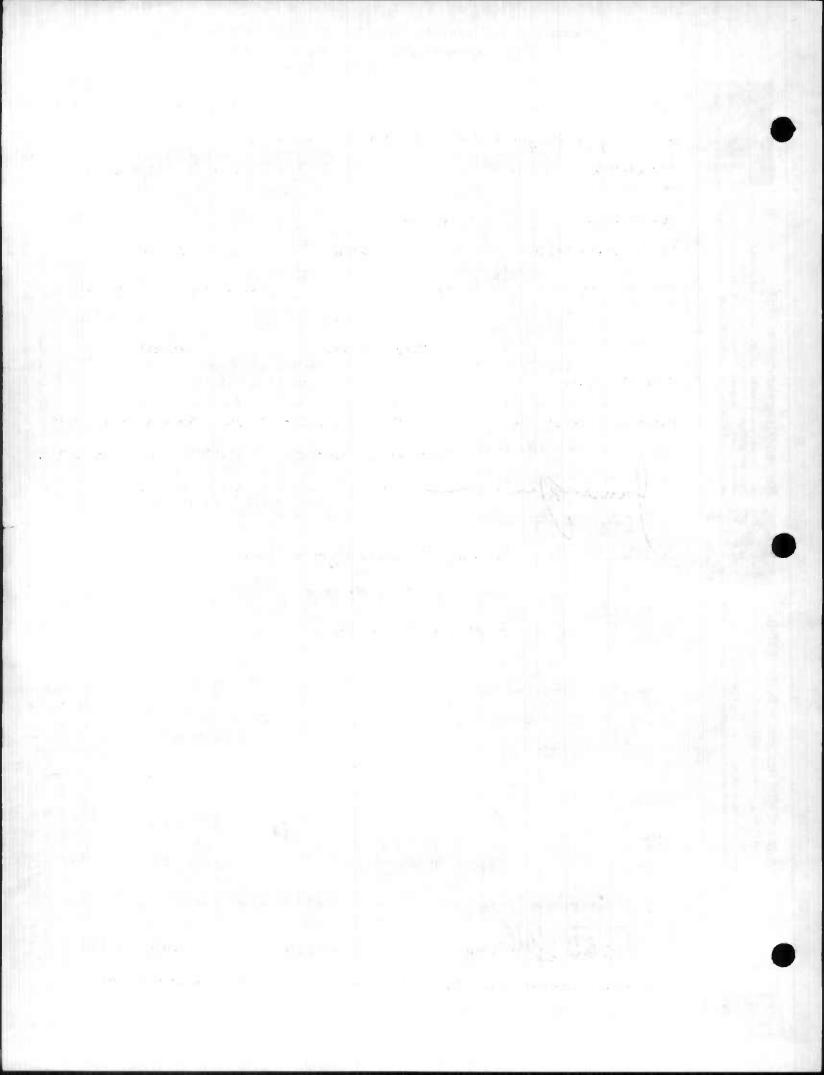
DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

JUL 171998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath **Physician** ulu Am /Medicai 4b. City, Town, or Location of Death lity Nama (If not Institution, giva streat and number) 4c. County of Death Examiner TOUSE VIE If Under 24 Hrs. If Under 1 Year 5. Social Sacurity Number 7. Age (In yrs. lest birthday) 6. Sax 8. Dete of Birth 9. Birthplaca (Stata or Foraign **Funerai** 1 M 2 F Days 241-36-7723 Usual Residanca of Dacedant Yrs Director 0 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show must be notified at 1 Yas 2 No Director AM 18 MDRE 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 26 29 Herns 23a NICE AZU Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☑ 1as 2 □ No If Yas, Give Yaar or Datas: 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. traumatic event, the Medical Examiner Peges 1 and 2 should be filed within 72 hours effer in ent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 Navar Married 2 Married 1 Yas 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Dacedent's Education (Specify only highest grada com 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry complated) Elementary/Secondary (0-12) Cotlaga (1-4or 5+) 12+1 NA INEES 17. Fethar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be M (= NOSON 19a. Informant's Name (Raletionship (Typa, Print) 19b. Mailing Address (Street end Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Peges 1 and 2 a Department of Health or Important: If Item 27 is any Injury or other trau NICE AVE 26 reah 10c 0 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathgd of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 DRamovat from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) JET. 21. Signatura of Funaral Sarvice Licenape 22. Nama and Address of Facility 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart filters. List only one cause on each line. Approximata interval Between Onset and Death **Physician** /Medicai 11 mos Immediata Causa (Finat Deficincy Disease disease or condition rasulting in death) Examiner Dua to (or as a consequence of) Physician/Medical Examiner Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Due to (or as a consaguanca of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. deteched 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown g Completed Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only one) Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) Hospi Ce 1 Yas 2₽No Medical Certification: To 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Data of Injury (Month, Dey Year) 27. Mannar of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Panding Invastigation 1 Natural

ettending physician and I for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by t peeu ate hes bege 2 s certificate the Hospital or Attending Physician: After this death. illed in by the Director: efter

the Maryland

Baltimore, Maryland 21215-0020

To the Hospital within 24 hours e To the Funeral C completely

State Registrar 2 Accidant

3 Sulcida

29a. Certitian

4 Homicida

29b. Signature and tillie of certific

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as steted.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signad (Month, Day, Year)

28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

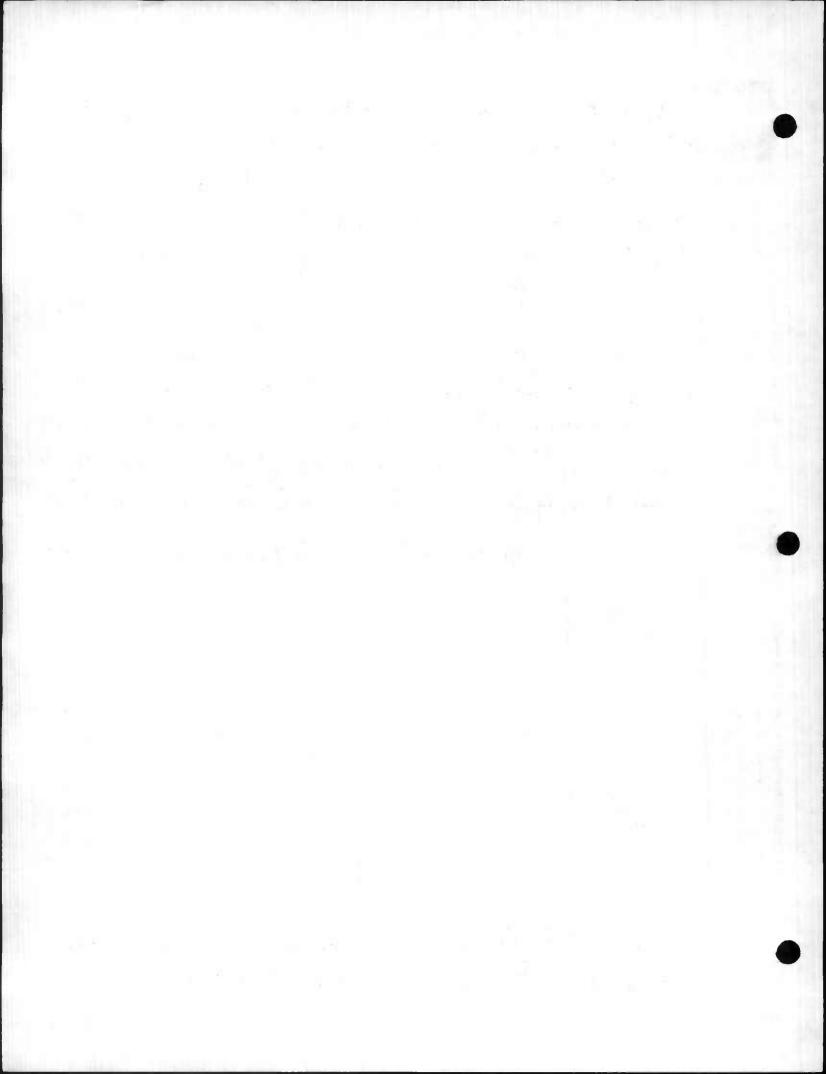
30. Name and addrass of person who completed cause of daath (ttam 23a) (Type, Print)

1 ☐ Yas

6 Could not be determined

rwin ou 32 Registrar's Signature

28a. Place of Injury - At homa, ferm, straet, fectory, office building, etc. (Specify)



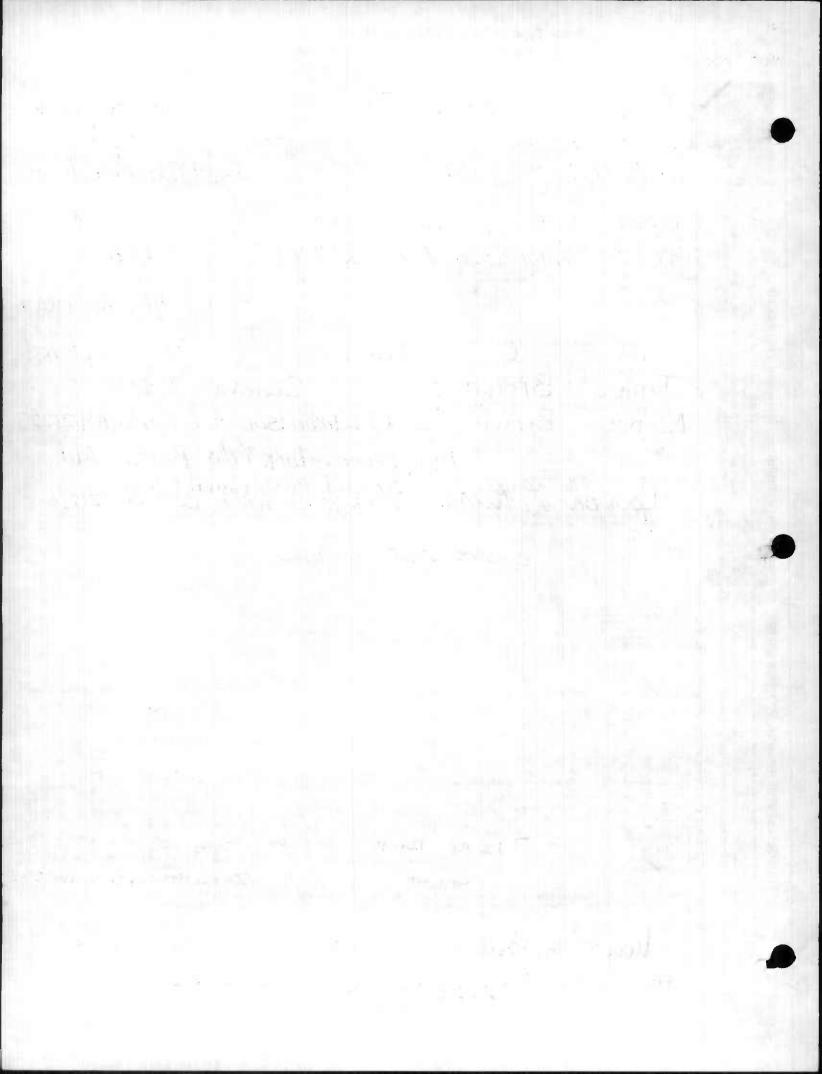
ADH 98-4014-510 JAMES BROWN JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Year **Physician** 12, 1998 JULY 1340 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner UNIVERSITY HOSPITAL BALTIMORE If Under 1 Year If Undar 24 Hrs. 7. Age (In yrs. last birthday) rthpiace (Stata or Foraign 5. Social Security Number **Funeral** Days 19-80-923 1.XM 2□ F Yrs. Director Usual Residence of Dacedant 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show traumatic evant, the Medical Examinet must be notified at 1 Yes 2 No Director Varyland mor 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? SA 25 21 Funeral do death 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuben, Maxican, Puerto Rican, etc.) or itams 14. Raca - American Indian, 11. Marital Status Black, White, etc. efter 1 ☐ Yas If Yes, Gir 1 Never Married 2 Married 2 XN0 1 ☐ Yes 2 X No Specify: à 3 Widowed 4 Divorced *American* Year or Dates 0 "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Eiementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be 2 should be fi end Mental H ie marked ott 10 zeneva (Sister) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 sh Department of Health end Important: If item 27 ie m any Injury or other traum pace. 12 own KOSIE altimore, 20b. Placa of Disposition (Name of cematary, crematory or other placa) Data, 20c. Location City or Town, State 20a. Method of Disposition 15 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) Memoria 22. Name and Address of Facility
JOSEPH L. RUS
ZZZZ W. Nor 21. Signyt unera tome US ass, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it is only ona causa on each line. 21216 Ba o. Md Approximate Interval Between Onsat and Death Physician Immediate Cause (Final disease or condition resulting In death) a GUNSHOT WOUND /Medical **Examiner** Due to (or as a consequence of) Examiner ettending physician end for use es the bunel-transit Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be exec Physician/Medical Dua to (or as a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed by Division of Vital Records. p 9 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed been this certificate hes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) uneral 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? 5 Pending 1 Natural MAS SHOT 98 2 DNO 1240p 1 Yes invastigation my same 2 Accident 12 24 hours after deat Funeral Director: 6 Could not be datemined 3 ☐ Sulcide 4 ☐ Homicide Location (Street and Number or Rurel Route Number City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office bullding, etc. (Specify) Hospital or 500 BLKMTHALY ST, BALTHOPE MY SMEET 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated Medical 29a. Certifie 2 TMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) To the Vithin 2 29b. Signature and title of certified 29c. Licensa number 29d. Date signed (Month, Dey, Year) 13, 1998 OCME. JULY ie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOWANDO A. WILLIAM Penn Street, Baltimore, Maryland 21201

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** ames rowr /Medical JIII.Y 1998 12:58 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of De Examiner 10 timo 18 5. Social Security Number If Under 1 Yeer If Under 24 6. Sex 7. Age (In yrs. Jest birthday) 9. Birthplace (State or Foreign **Funeral** 423-40-6302 Days 1 MM 2□ F 4 la Bama Yrs. **Director** Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Madical Examiner must be notified at Maryland **Funeral Director** 1 Yes 2 No mor 10e. Str et and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 21 na50 d 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Stetus filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 X If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Fro-Hmerican Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life.j DO NOT juse retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. d 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health end Mentai Brown erman 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number Rural Route Number, City or Town, Stete, Zip Code) Kosie nt of Health e if item 27 is or other tra Md. 21229 Dalto. 10 20a. Method of Disposition 20b. Placa of Disposition (Name of Date / 20c. Location - City or Town, State 1 Burlal 2 □ Cremation 3 Removal from State Department of Important: if any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Hom, hease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ilure. List only one cause on each line. 21216 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final na-MONE disease or condition resulting in deeth) Examiner Due to (or as Examiner The law requires that the death certificate be executed for use as the bunel-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): cate has been signed by the e pege 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1⊈ Yes 2□ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 No certificate 1 ☐ Yes 2 ☐ No Vital Attending Physician: director, 25. Was case referred to medical Be 26. Place of Deeth (Check only one) 15 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 1- Natural 5 Pending Investigation death. 1 ☐ Yes 2 No 2 Accident or Attend after death Director: the 3 Sulcide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) à 4 - Homicide 29e. Certifier Certifying Phyelctan: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated. Certaining in registration in the best of my stowards, deed in the cause (s) and death occurred et the time, dete end ptece, end due to the cause(s) and manner stated. (Check only one) To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) >u-

State Registrar 30. Name and add

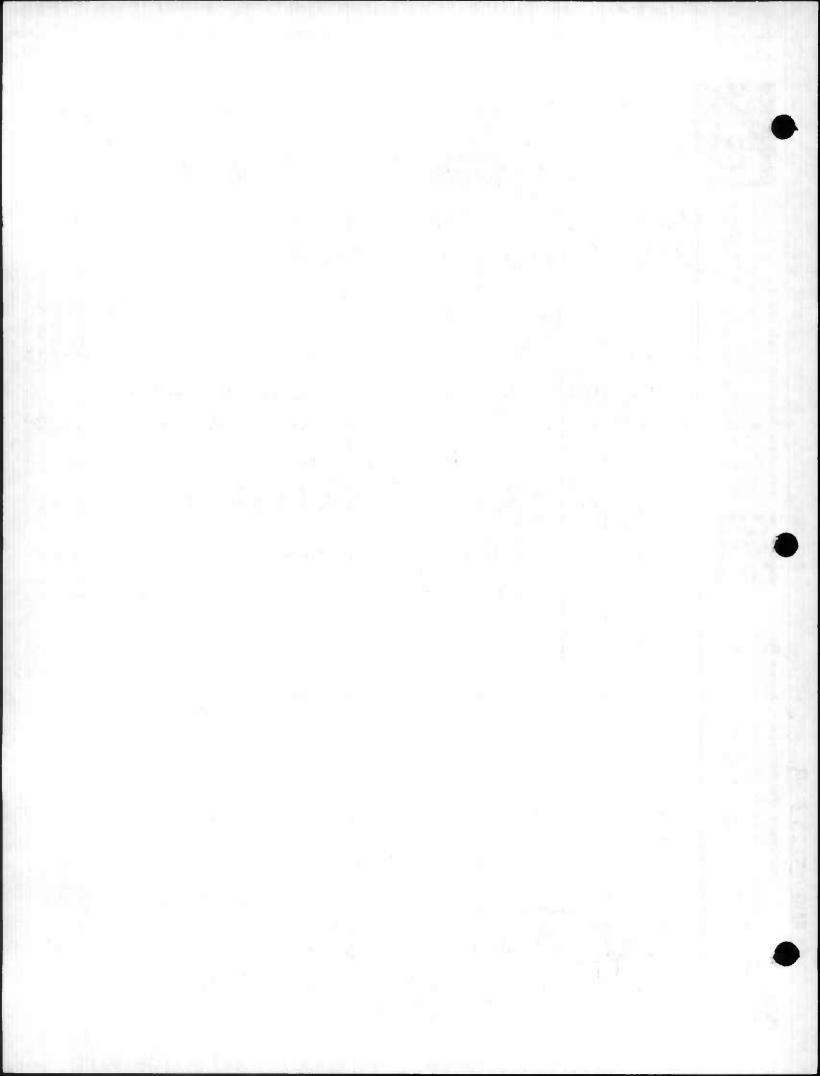
31. Date filed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

Ba Itmon

Same

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98-4037-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene UNK. 98-149 Certificate of Death Antonio Brockington 2. Dete of Death 3. Time of Death nt's Nama (First, Middle, Last) JULY 14, Dey 1998 Yaar **Physician** 01:40 AM ./Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Nema (If not institution, giva street and number) Examiner 1501 ASHBURTON STREET BALTIMORE 5. Social Security Number 216 - 84 274 Usuel Residence of Decedent If Undar 24 Hrs. If Under 1 Year 9. Birthplace (Stata or Foreign 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Deys Months Hours 10 M 2 F Yrs. Director with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Yes 2 No Maryland Directo mor 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code ne ol dd Funeral death Wes Decedant Evar In U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. 14 Race - American Indian 11. Marital Stetus Bieck, White, etc. should be filed within 72 hours after and Mentel Hygiene. 1 ☐ Yes 2 No ff Yes, Give Yaar or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Frican þ *Hmerican* 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mentel Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) esman (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame, Be Imother ng Address (Street and Number or Rural Route Number permit. Pages 1 end 2 sh Department of Health and Important: If them 27 Is m Sex, Md. 21221 ington Pleca of Disposition (Name of compteny, crematory or other place) 20c. Location - City or Yown, Stete 20e. Method of Disposition 1 Buriei 2 ☐ Cremetion ò 3 Ramovel from State any Injury 4 ☐ Donetion 5 ☐ Other (Specify) -10r 22. Nama and Address of Facility
JOSEPH L. K
2222 W. NOF 5 2222 W. North Ave.

123, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, the control of the c Approximete interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical quashot Examiner Due to (or es e consequence of): force Examiner ettending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequença of): Box 68760 Physician/Medical Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 1 Yae 2 No 3 Probably 4 Unknown Division of Vital Records, þ 8 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? Completed 24e. Was en autopsy performed? has 12 Yes 2 No 1 Ves 2□ No certificate 25. Wes case referred to medical examiner?
1 △ Yes 2 □ No Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpetient 3 DOA this funaral 27. Manner of Deeth 28d. Describe how injury occurred Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: After Injury Subject snot and struck Attending 1 Natural 5 Pending death. 1 Yes 2 No with blunt object
281. Location (Street and Number or Rural Route Number,
City or Town, State) 1501 AJhburten St. invastigation 7-14-98 2 Accident untrown eftar deat 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) Homicide ò | Tound in Parting area | Baltimore City, Maryland Hospital 24 hours 29a. Certifier Medicai Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated. (Check only one)

29c. License number

111 Penn Street, Baltimore, Maryland 21201

OCME

29d. Date signed (Month, Day, Year)

JULY 14, 1998

State Registrar

within 2 the

29b. Signature end title of certifier

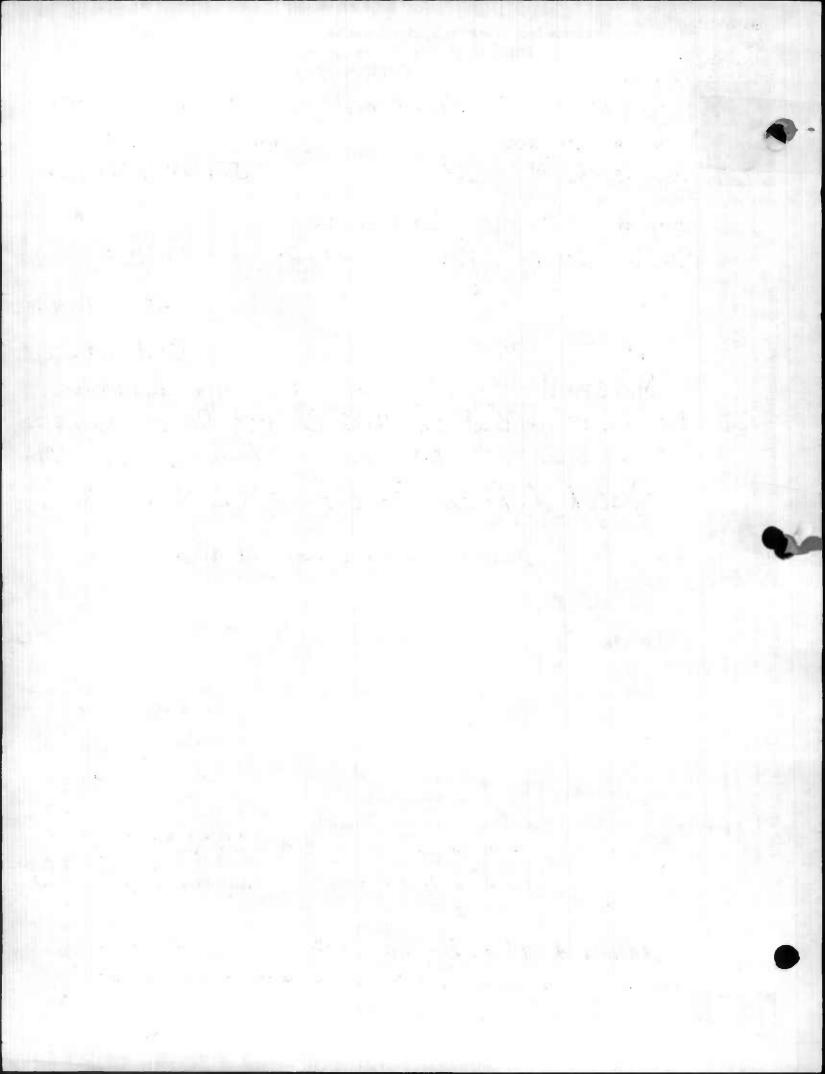
Stephen
31. Dete filed (Month)

30. Name and eddress of person who completed cause of deeth (flem 23e) (Type, Print)

51

Radentz

Signature Davidson

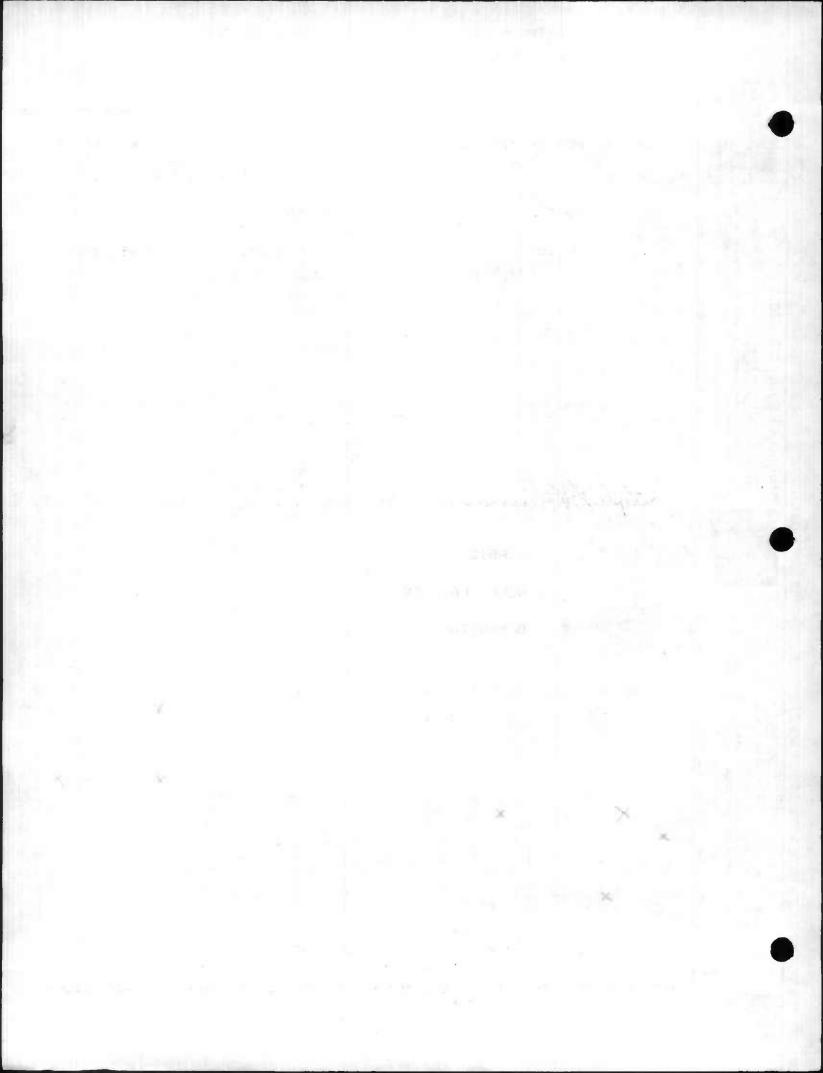


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Dev Month **Physician Gladys** Lee Belcher 15. 1998 07:45 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Towson Saint Joseph Medical Center Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2MF Months Days 89 226 03 0409 Director Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Virginia Campbell Lynchburg 1 Yas 2 □ No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? b must be 113 Langhorne Lane (Unknown) United States harms 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, etc. the Medical Examiner 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Maryland 21215-0020 à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 and 2 should be filed w Department of Health and Mertal Hygies (important: if teen 27 is merked other th any Injury or other in-Domestic 12 17. Fether's Name /First. Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Rufus McAlexander Minerva Kessler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Belcher / Son 508 Sussex Rd., Towson, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 7/17/98 Green Mount Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licens 22. Nama end Address of Facility CAFA Stephen D. Lohrmann P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Dr., Baltimore, MD 21286 Approximete Interval Betwe Onset and Death , Physician Immediate Cause (Final disease or condition resulting in death) /Medical SEPSIS Examiner Due to (or as a consequence of) Examiner b. RENAL FAILURE physician and s the burtal-transit be assouted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. c. DEMENTIA Physician/Medical certificate Due to (or as a consequence of): 88 -87 Po P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 94 signed by t 1 Yee 2 No 3 Probably 4 Unknown The law requires that PERIPHERAL VASCULAR DISEASE Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy peeu has page 2 1 Yes 2 No 1 TYAS 2 NO certificata of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 28s. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After Division Attanding 5 Pending investigation 1 M Natural I or Attanding after death. I Director: After 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, atreet, factory, office building, etc. (Specify) 4 Homicide 24 hours Hospital TIC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investination. In my pointer, death occurred at the time date and place, and due to the edical 29a. Certifie To the Hosp within 24 ho To the Fune completely ti miner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mapper stated. (Check only one) 29b. Signature and title of centre 29c. Licensa number 29d. Date signed (Month, Day, Year) D44728 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITCHELL SCHWARTZ, M. D., 6565 N. CHARLES STREET, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) State JUL 171998 Registrar

DHMH 16 Rev 6/95



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	Decedent's Name (First, Middle, Last)	Certificate	Or D'Outri	2. Dete of Death	g. No.	3. Ti	me of Death
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rector	MD N/	Λ Τ	Baltimore				1X	Yas 2□No
Funeral Director	10e. Street and Number	A	10f. Zip C	ode	10	g. Citizen of Wi	hat Country?	
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To	19a. Informant's Neme/Relationship (T			Street and Number or Plura				
3 E	Robert D. Bu			Belveder		-		
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ai Examiner	Sequentially list conditions.	0.	es a consequence of):	,,,,,,			0	
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edicai	thet initiated events resulting in deeth) Last	C. Due to (or	as a consequence of):				1	
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Be	examiner?	Hospital: 1 Inpatient 2 E	R/Outpatient 3□ DOA	26. Place of Deet		nce 6 Othe	or (Spenify)	
rai director. 7: To Be (27. Manger of Death			4LI Nursing Ho	28d. Describe ho			
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led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	ne, farm, streat, factory.	office	28f. Location (Sti	aet and Numbe	er or Rural Route	a Number,
er.	4 Homicide determined	building, etc. (Specify)			City or Town	Stete)		
ai C	29e. Cartifier Certifying Phy	sician: To the best of my know	ledge, death occurred et	the time, dete end place,	and due to the ca	use(s) end mar	nner es steted.	
pletaly fil edical	(Check only 2 Medicat Exam	ner: On the basis of exemination and menner stated.	on and/or investigetion, in	my opinion, death occurr	ed at the time, da	ite and pleca, e	nd due to the ca	use(s)
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We .	29b. Signature and title of certifin	Mu mi		D16587		7/16/	48	
completely filled in by	> Chul	ompleted cause of death (Item	23e) (Type, Print)	D16587		+1161	48	
Compl	30. Neme and address of person who c	a. A 1. 3 /	23e) (Type, Print)	D1658-1	mine, 1	4/16/	239	
To the Funeral Director: After this certifica completaly filled in by the funeral director, and Medical Certification: To Be C	30. Name and address of person who c	ompleted cause of death (Item 560 / Lo 32 Registrar's Signate		D1658-1 3 (vd, Balt.	mine, 1	4/16/	239	

DHMH 16 Rev 6/95

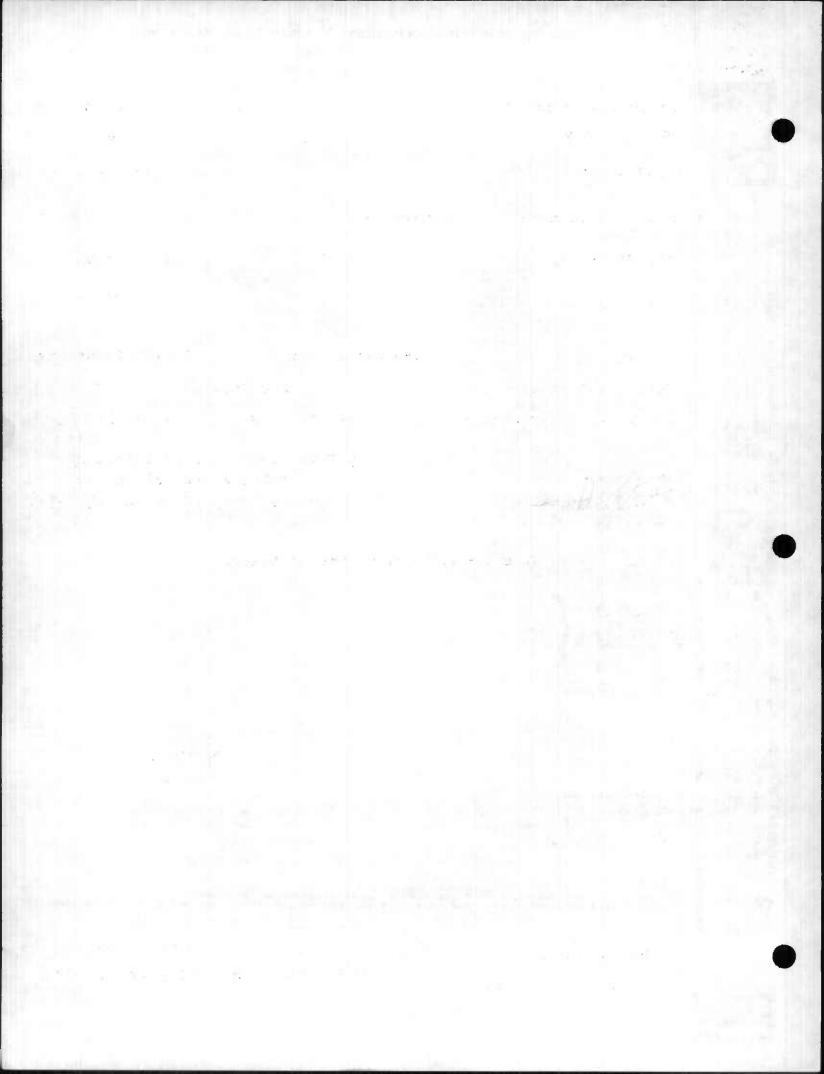
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State of Maryland / Department of Health and Mental Hygiene 98

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Registrar



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						Ce	rtificate d	of Death		Reg. No.		
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	/Medic		4a. Facility Name (If not Institution, giv	re street end number	7)			4b. City, Town, or			3	0-31 444
	LAGIIII	161	Charles town	Care	(+ 1	ter		Cator	sville	Re	lti	more
D	uneral irector		Social Security Number 6. S			est birthdey, Yrs.	If Under 1 Y. Months De	aar If Under 24 Hrs		25,1923	9. Birthp Coun Pen:	olace (State or Foreign otry) nsylvania
Maryland	Importants if results are residuely lygens. Importants if less in a reflect other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	10a. State 10b. County Maryland Baltimon	re	,	Town or Lonsvi					1	0d. Inside City Limits Date 2 No
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21215-0020 d within 72 hours efter	al', or its Examine	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2☐ If Yes, Give Year or Datas:	ķΝο		1 ☐ Yes 2 ☐		to rican, etc.)	Specif	ck, White,	
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10			23a. Part1. Enter the disaasa, or com shock, or heart failure. List only	plications that cause one ceuse on each	d the death line.	. Do not en					20/1.	Approximate Interval Between Onaat and Daath
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To the within 2	To the comple	×	29b. Signatura and title of cartifier				29c. Lic	ensa number		29d. Date signe	d (Month,	Day, Year)
• ,-	4		30. Name end address of person who	Completed Pause of	M)	23a) (Type	Print)	51051		July	12	2 1998 MD, Z1228
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Deeth July 13,1998 7:30 AM Elizabeth Anne Blum 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Worcester Berlin Atlantic General Hospital Hours Min. 8. Date of Birth (Month, Dev. Year) Feb. 27, 1958 5. Social Security Number If Under 1 Year 6 Sax 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign 1□ M 200XF Days 219-74-0656 40 Yrs. Michigan Usual Residenca of Dacedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland Worcester West Ocean City X□Yes 2□No 10e. Street and Number 10g. Citizen of What Counfry? 10f. Zip Code 21842 12626 Sunset Avenue United States 12. Was Decedent Ever in U,S. Armed Forces? Raca - American Indian, Black, White, etc. 11 Marital Status 13. Was Decedenf of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 XX Married 1 ☐ Yes 2 ☐ No Specify: Specify: White No No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Executive Secretary U.S. Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Anne Marie Doyle Larry Edward Reagin 19a. Informent's Name/Refationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Stephen C. Blum/husband 12626 Sunset Avenue W.Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 United 2 Cremation 3 Removal from State onation 5 Other (Specify) Lakemont Memorial Gardens 7/17/98 Davidsonville, MD 21. Signature of Funeral Service Libensee 22. Name and Address of Facility ameran Robert E. Evans Funeral Home, Inc. 16000 Annapolis Road Bowie, MD 20715 complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, only one cause on aech line. Approximata Interval Between Onset and Death ate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 20 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medicai Examiner

> and the burial-tran

Physician/Medicai

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Be

Certification: To

Medical

3 Suicide

29a. Certifier

4 | Homicide

(Check only one)

page 2 should Completed

The law requires that the death cartificate be executed

P.O. Box 68760,

Records,

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Division

or Attending Physician:

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To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this complately filled in by the funeral

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Physician

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Director

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Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

Hospitel: 1 Yas 2 No npatient 2 ER/Oufpatient 3 DOA 27. Menner of Death 28b. Time of 1 Natural 2 Accident

5 Pending investigation 6 Could not be

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28d. Describe how Injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Cartifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete and placa, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner stated.

29b Signatura and title of certifier Went 29c. License number

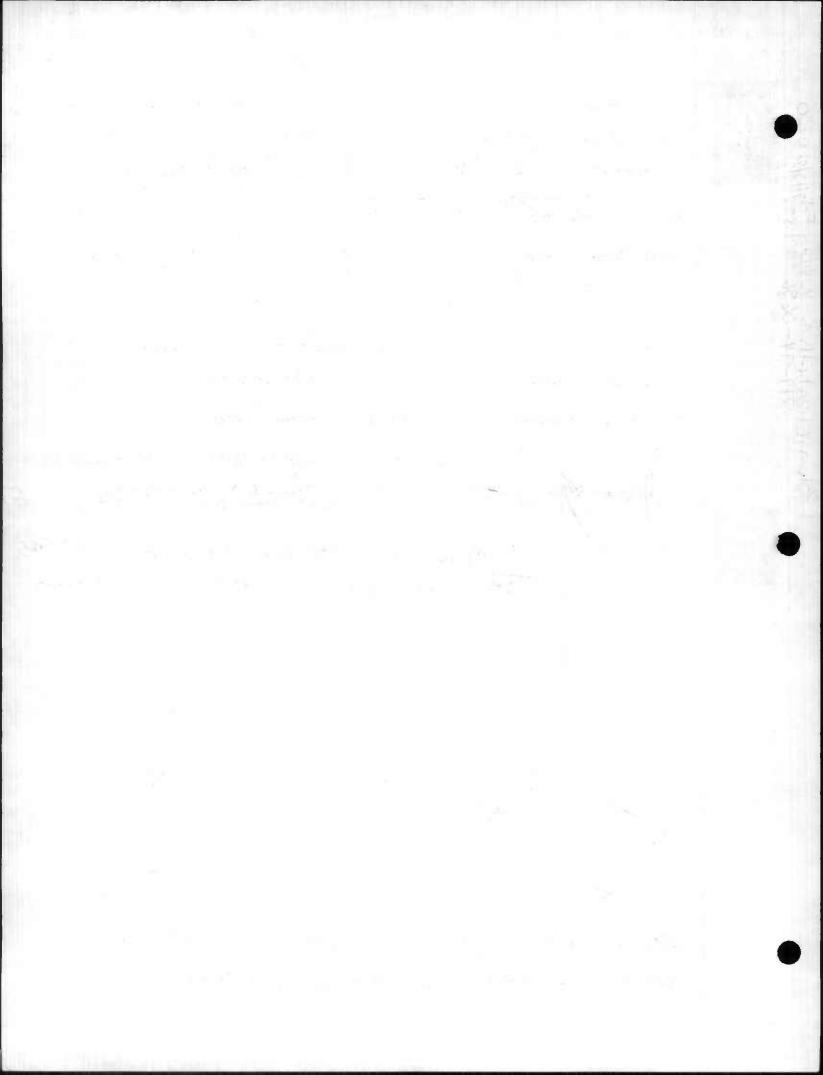
28c. Injury at Work?

29d. Date signed (Month, Dey, Year)

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

1908 32 Station Deviden Andrew Dr Boern 31. Date filed (Month

State Registrar

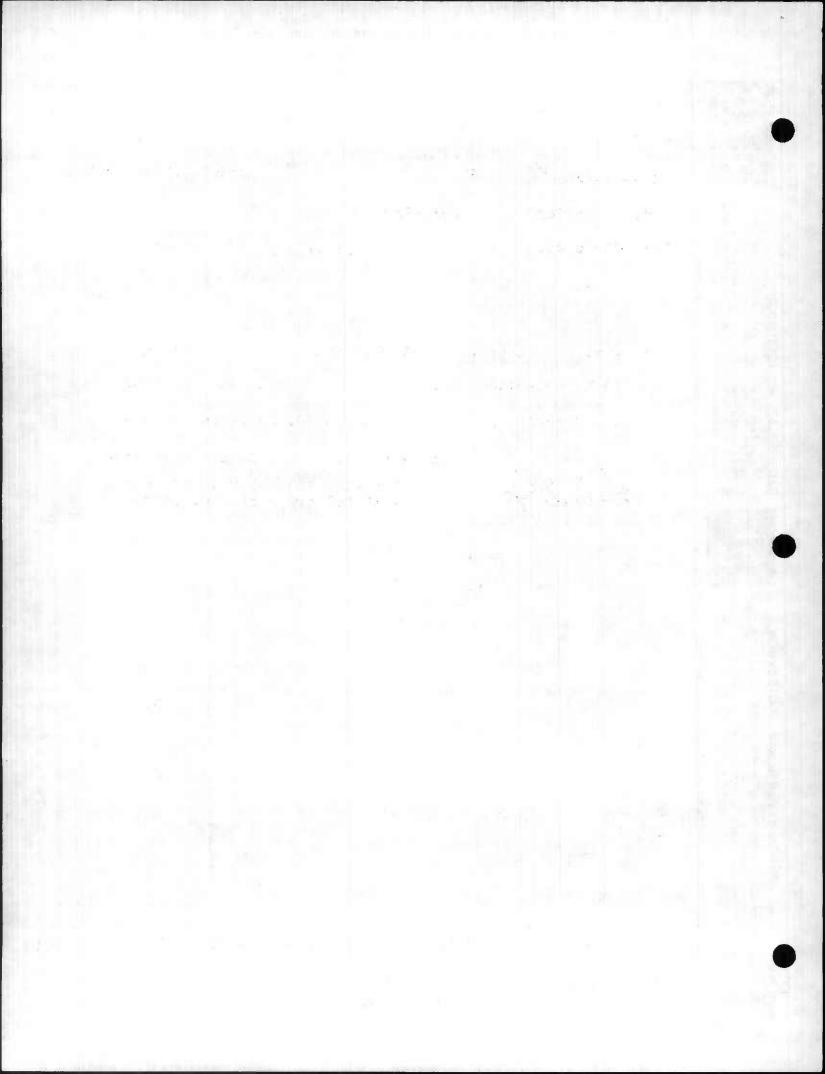


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State of Maryland / Department of Health and Mental Hygiene

Di-	Decedent's Nama (First, Middla, Last)		Reg. No.	3. Time of Deeth						
Physician /Medical	I LOW WILL CONTAINED W		July 15	1998 17.11						
Examiner	University of Maryland	Baltimore, M		ounty of Death USA						
neral ector	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 7. Age (In yrs. last birthdey) 4. Months Usual Residence of Decedent	1 Year If Under 24 Hrs. 8. De Company Min. De Company Min.	ate of Birth Month, Dey, Year) C.12,194	9. Birthplace (State or Foreign Country) 2 Maryland						
notified at	10e. Stete 10b. County 10c. City, Town or Location	IN THE STATE		10d. Inside City Limits						
rector	Md. Harford Fallston		40. 0**	1 □ Yes 2 No						
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Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evar in U,S. Akmed Forces? 1. Yes, Sive Year or Dates: 13. Was Decedent Evar in U,S. Akmed Forces? 14. Yes, Give Year or Dates:	ent of Hispanic Origin? (Specify Y ify Cuban, Mexicen, Puarto Ricen Mo Specify:		. Reca - American Indian, Black, Whita, etc. pecify:White						
leted	15. Decedent's Education 16a. Decedent's Usua (Specify only highest grade completed) (Give kind of wor	i Occupation k done during most of working e retired)	16b. Kind	of Business/Industry						
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Be	17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumema) Reference of the state of the s									
P	Franklin M. Cornelison Sr. Myrtle Reed Winkler 19a. informant's Neme/Raiationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code)									
		lo Rd. Falls								
	20e. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nem cemetery, crematory or of Oaklawn Cem	har pleca)		ation - City or Town, State						
any injury or other traumatic event, the models once. To Be Completed	Connel	d Addrass of Facility Lly Funeral Ho Sollers Point	ome Of D	oundalk						
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ical Ce	29a. Certifier (Check only (Ch	at the time, dete and piace, and d	ua to the ceuse(s) a the time, date and p	nd manner as stated. siace, and due to the cause(s)						
completely filled Medical Ce		Licansa number U 4176435 - Q-	-	signed (Month, Day, Year)						
	30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) A mer Quaddours 13-E Queentree	4. Baltim	1M gra	21244						
State Registrar	31. Date filad (Month, Day, Yeer) 32. Roomants Signature 32. Roomants Signature									

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nema (First, Middla, Last) 2. Deta of Deeth **Physician** 13, JULY Vera Ellen Colangelo 1998 4:14pm /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, give street end number) **Examiner** Gilchrist Center Towson Baltimore If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) if Undar 1 Year 5. Sociei Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 1 M 2 K Months Days Yrs. 248-38-1880 67 17, 1930 South Carolina AUG. Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 🏖 No Directo Maryland Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3295 Ellmede Road 21042 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedant of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Bieck, White, etc. 1 ☐ Naver Merried 2 ☐ Married 1 Yas 2 No Specify: by 3 ☐ Widowed 4 N Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 1 2 College (1-4or 5+) Business Owner Bridal Shop 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Sumeme) Unk. Margaret Unk. 2 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. informent's Neme/Reletionship (Type, Print) daughter 3295 Ellmede Road Ellicott City, MD 2
Dete 20c. Location - City or Town, Stata Cynthia Caroline Vitacolonna MD 21042 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) 20e. Method of Disposition 1 ☐ Buriei 2 X Cremetion 3 ☐ Removei from State Metro Crematory, Inc. 4 ☐ Donetlon 5 ☐ Other (Specify) 7/14/98 Baltimore, MD 22. Nama end Address of Fecility Cremation Society of Maryland, Inc. 23a. Part1. Enter the disease, or complications the Complete to the Mode of dying, such as cardiac or respiratory errest, Approximate Approximate Approximete intervel Between Onset and Death e. Amyotrophic Lateral sclerosis
Due to (or as e consequenca ot): immediate Cause (Finel disaesa or condition resulting in death) Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es a consequence ot): Due to (or es a consequenca of) resulting in daeth) Last 23b. Did tobacco use contributs to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No by 24b. Wera eutopsy findings avalleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospice 0 1 ☐ Yes 2 ☑ No 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27 Manner of Death 28c. tnjury et Work? Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

that the death certificete be executed Division of Vital Records, P.O. Box 68760, or Attending Physician:

physician and the burial-transit 88 page 2 s certificate this After death. Director: / • Funeral Dire

Funeral

Director

an "natural", or liams 23a or Medical Examiner must be

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Physician

/Medical **Examiner**

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2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) and menner stated. 29c. Licensa number

🖄 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner es steted.

28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify)

29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Neme end address of person who completed cause of death (Item 23af (Type, Print) 6-BMC 6701

6 Could not be determined

3 ☐ Suicide 4 Homlcide

(Check only one)

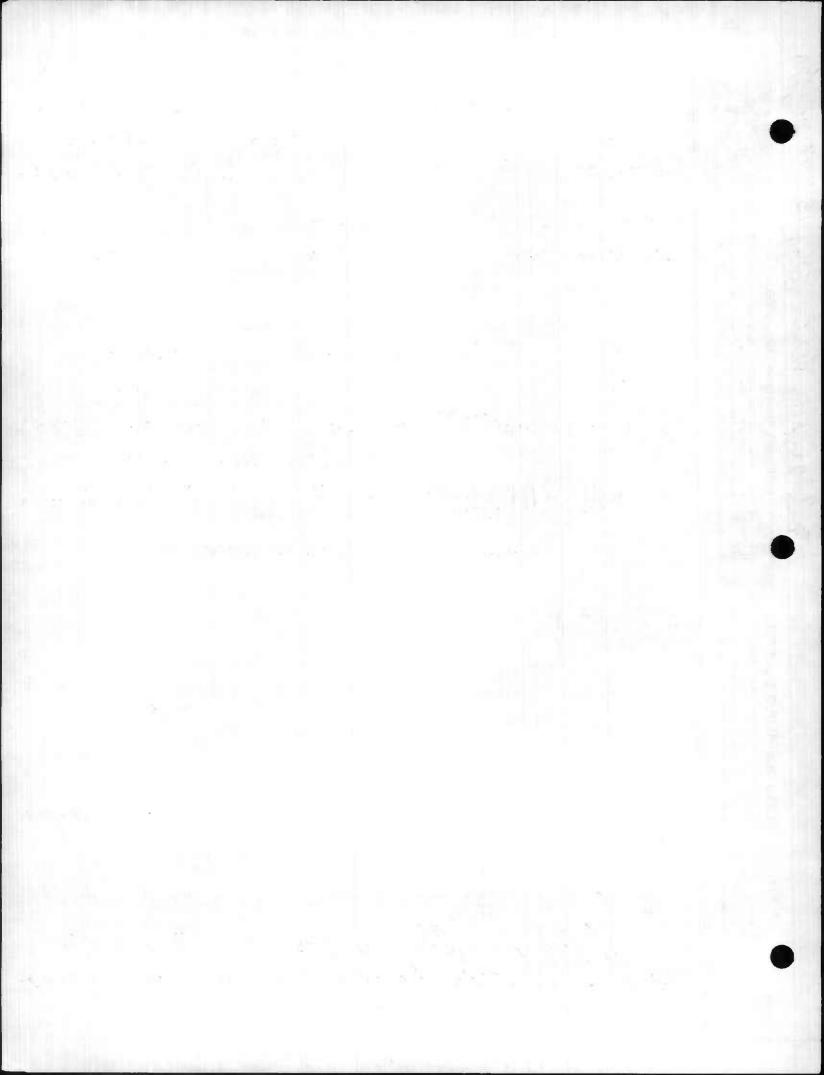
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29b. Signature and title of certifie

29e. Certifier

N. Charles St. Balto. MS 2120x

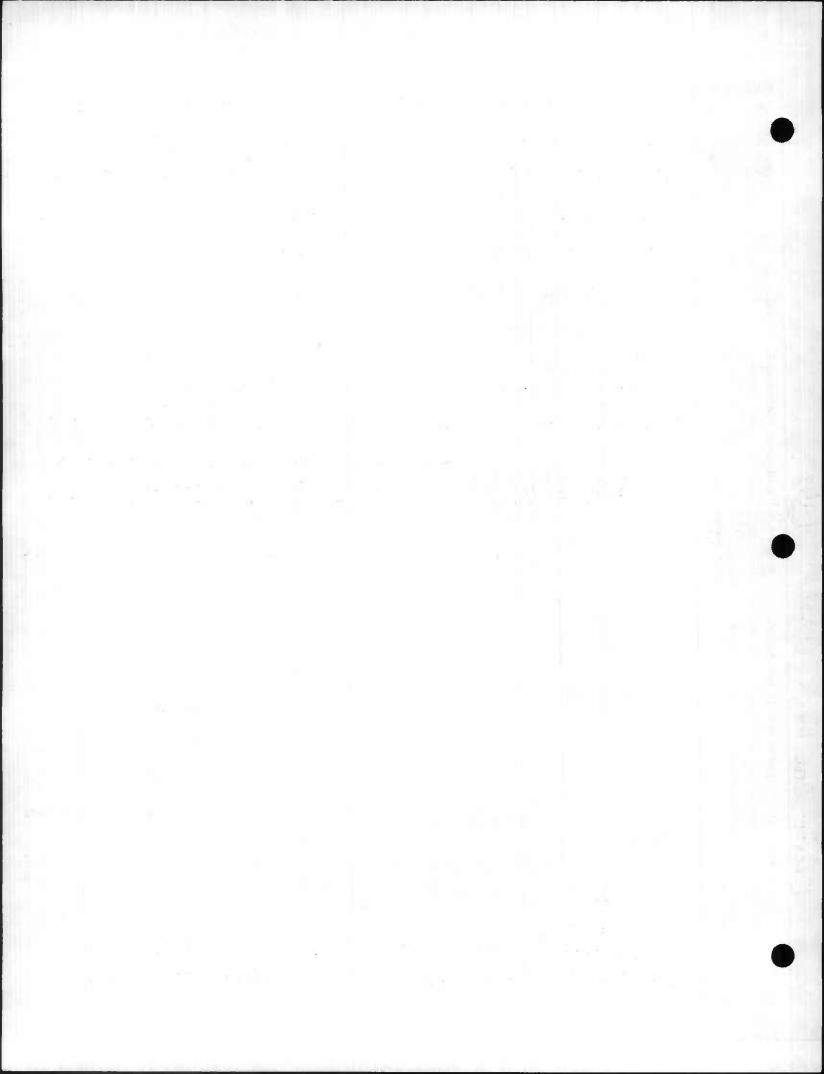
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State of Maryland / Department of Health and Mental Hygiene 98

					Certific	ate of	Death		i P	leg. No.	£	
		1. Decedent's Name (First, Middle, L	ast)						2. Date of Dea		Vees	3. Tima of Death
	Physician	E1o	ise Wel	ch Caro	thers				JULY	14, 19	98	12:30pm
	/Medical Examiner	4a Facility Name (If not institution, gi	ve street and num	ber)		-	4b. City, To	wn, or Lo	cation of Death			
	Examine	Gilchrist Cen	ter				To	WSOI	1	Ba1	timo	re
	Comment			. Age (In yrs. last bi	irthday) If Ur	nder 1 Year	If Undar		8. Date of Birth (Month, Day			
	Funeral Director	214-30-9307	1□M 2 F	64	Yrs. Mont	hs Days	Hours	Min.	JUNE 5,	1934	Coun	lace (Stete or Foreign stry) Virginia
		Usual Residance of Decedent							JOINE 7,	1757	1100	111611111
	July 8 m	10a. State 10b. County		10c. City, Tow	wn or Location						1	0d. Inside City Limits
	Wery tash	Maryland Balti	more		W	hite	Hall					1 ☐ Yes 2√ No
	5 28 E	10e. Street and Number				Zip Code				l0g. Citizen of \	What Cour	ntry?
	with or or	2 Old Garrett	Court			. 2	1161			US		
	era	11. Marital Status		dant Evar In U,S.	13 Was De	acedent of H	tispanic Orig	nin? (Spe	cify Yas or No-		e - Americ	can Indian.
	within 72 hours after death with the Merylend ene. than "natural", or items 23a or 28e-f show fre Med call Elections from the Indianal Director	1 Never Married 2F Married	Armed For	ces?	It Yes, s	specify Cube	an, Mexican	Puerto	Ricen, etc.)		ck, White,	
5	urs af	1 Nevar Married 2 Married 3 Widowed 4 Divorced	It Yes, Give	Δ	1 ☐ Ye	s 2 No	Specify:			Specify	Wh	nite
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L T	L L L I S-U led within 72 ho tygiene. her than "neturn nt, me Med call Completed	(Specify only highest g	rede completed)		(Give kind of life. DO NO	work done	during mos	of worki	ng			,
5	with with the same of the same	Elementery/Secondary (0-12)	College (1-		[omema]		,		1	Domest	ic	
7	Hygid Hygid	17. Fathar's Name (First, Middle, Las	t)	11	iomema.	KEI	18. Mothe	r's Name	(First, Middla,			
	The fill be fi		•						ian Bo		,	
3	Tourid Tourid	19a. Intormant's Name/Relationship		101	b Admilia a Andri	/Ctt			l Routa Numbe		Clota 7in	Codel
3	Maryland ZIZIS-UUZU d2 should be filed within 72 hours aft h end Mantel Hyglene. 7 is marked other than "natural; or traumatic event, the Medical Exam To Be Completed by F		. ,,									
	m 27	Richard E. Car	others		ot Disposition (rett	Cour	t Whi	te Hall		
	P F F F F F F F F F F F F F F F F F F F	20a. Method of Disposition 1 ☐ Burial 2 分 Cremation 3 l	Removal from S	comete	ery, crematory	or other plac	ce)	1	Date	20C. LOCATION	City of 10	own, State
1	Ped Ped Ped Ped Ped Ped Ped Ped Ped Ped	4 Donation 5 Other (Spec			Cremat				/15/98	Balt	imor	e, MD
38	perilimore, maryiand ZIZIS-00Z0 permit. Pages 1 and 2 should be filed within 72 hours after death with the Menylen Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 23s-f show appriliphry or other traumatic event, the Medical Examination notified at ance. To Be Completed by Funeral Director	21. Signature of Funeral Service-Lice	assemple -	mald	22. Name	and Addre	ss of Facilit	y i o t i	y of M	orulor	d T+	
0	0 88558	Dawn F.	McDona	ald.								ID 21228
2 MB		23a Part1. Enter the disease or cor	notications that ca	used the death. Do	not enter the r	mode of dyir	ng, such as	cardiac o	or respiretory ar	rest,	, 1	Approximate Interval Between
7	Physician	shock, or heart tailure. List only	y one cause on aa	cri line.							1	Onset and Death
	/Medical	Immediate Cause (Final	\sim	etasta.	150	color	20 (an	cov		1	6 years
-	Examiner	disaasa or condition resulting in death)	a	Due to (or as a			P1 -	- 817 - 1			1	1-1113
2	<u> </u>			Due to (or as a	Consequence	Oi).					1	
N	X 00/00, artificate be executed ling physician end e as the bunel-transit Medical Examiner		b	Due to (or as a	00000000000	ot).						
30	exection of the secti	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury		Due to (or as a	consequence	01).					l l	
2	Sicial burn	Causa (Disease or Injury that initiated events	C	Due to (or as a		-0.						
7	BOX 607 00, eeth certificete be executed ettending physician end for use es the bunel-transit clan/Medical Examir	resulting in death) Last		Due to (or as a	consequence	01).						
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50 0	est the deeth codes the deeth codes the deeth codes the								L not milion		-1-141-1	
2	. 0 00 0	Part II. Other significant conditions	contributing to dea	ath but not resulting	In the underlyii	ng cause giv	en in Part I	•				o the cause of death?
LER.	Thett								10	Yes 200 No	3∐ Pro	bebly 4 Unknown
arother	Invision of Vital Records, F.O. Bo, or Attending Physicien: The law requires that the deeth of effect death. Director: After this certificate has been signed by the attend tin by the funeral director, page 2 should be deteched for us ertification: To Be Completed by Physiciany								24a Was	an autopsy	24b W	ere autopsy tindings
0	been sibould								perfo	med?	av	railable prior to empletion of cause
2	The law ste hes b page 2 s										of	death?
2	The law requir sate has been s page 2 should								101	es 27 No	1(☐Yes 2☐No
9	ysicien: The lav ysicien: The lav is certificate hes director, page 2						26. Place	of Deatl	(Check only o	ne)		,,,
111	Physicien: this certific and director,	1 ☐ Yes 2 NO No	Hospital: 1 In	patiant 2 ER/O	Outpatient 3	DOA Oth	her: 4 🗆 Nu	irsing Ho	me 5 Resid	lence 6 Ott	ner (Specil	M Hospice
351015	or the period of		28a. Date of	t Injury 28b.	Time of Injury	28c. Injul Wor	ry at		28d. Describe h	now injury occu	rred	
5	Attending r death. Sector: After by the fune fill cation	1 Natural 5 Pending 2 Accident investigation		,, 50, 700,	М		Yes 2	No				
7 .	Atte or de by the by the by the	3 Sulcide 6 Could not determine	d 286. Place	of Injury - At home, f	farm, street, fac	ctory, office			28f. Location (S		ber or Run	el Routa Number,
1.1	bio or Attending P rs effer death. al Director: After tied in by the funers Certification:	- I Homicide	buildin	g, etc. (Specify)					City Of TOR	ni, State)		
N	Hospital Runoral Funeral Mely filled			pest of my knowledg								
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	(Check only 2 Medical Exe		sis of examination a								
	within 2 To the comple	29b. Signature and title of conflier	11	111		29c. Licens				29d. Date signe		
	F × F 0	30. Name, and address of person who complified cause of down from 23e) (Type, Print) Charles St. Bit.							-	July/	4.19	98
	10	20 Name and address of several	complete and	of due to the one	(Type Delet)		3				1	. 0
	l	30. Name and address of person who	completes cause	md (20)	I N.C	Charle	s St.	Bn	elto-0	nd 2	120	8
		31. Date tiled (Month, Day, Year)	32 84	gistrar's Signature	, ,,				18			
	State Registrar	JUL 171998	9	gistrar's Signature	Mandelle							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Day **Physician** Rose F. Chipman JULY 14, 1998 9:50 AM /Medical 4a Facility Nama (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson 8. Date of Birth NOV. 28, 1914 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 □ M 2 🛛 F 214-01-1059 83 Yrs. Director Maryland Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Maryta 1 Yes 2 No Directo Maryland Baltimore Catonsville 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 715 Maiden Choice Lane Apt CR503 21228 USA Norms 23a Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yas 2 ☐ No
If Yas Give A 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, etc. 72 hours after 1 Nevar Married 27 Married Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 ☐ No Specify: Specify: ğ 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) Statistician State of Maryland 12 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked oth any injury or other traumatic event any injury or other traumatic event any injury or other traumatic event Be Herbert Lewis Fleming Margaret Elizabeth Kealey 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Richard R. Chipman/son 1571 Harpers Cove Lane Reston, VA 20194 20a. Method of Disposition

1 Burial 2 Cramation 3 Ramoval from Stata

Lorraine Park Mausoleum 20c. Location - City or Town, Stata Data 7/17/98 Baltimore, MD MacNabb Funeral Home, 21. Signature of Funaral Sa Dawn F. 1c Amala P.A. 301 Frederick Road MD 21228 McDonald Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician GRAM-NEGATIVE SEPSIS /Medical Immediata Causa (Final disease or condition rasulting in daeth) Examiner Dua to (or as a consequence of) Examiner BILIARY OBSTRUCTION attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 2 2 No 1 Yes 2 No 1 Yes To the Hospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case refarred to medical examinar? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Netural 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 THomicide 29e. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 7-14-98 10hon D 30263

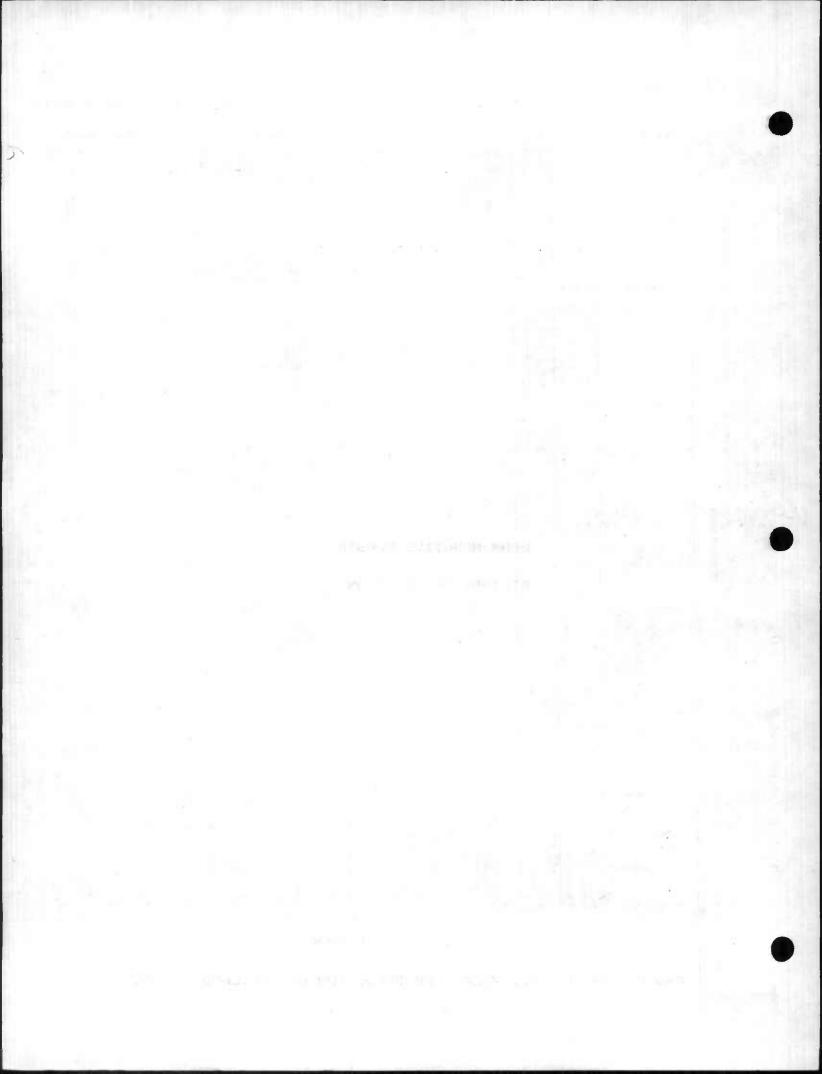
30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

FRANCIS KHOO, M. D., 31. Date filed (Month, Day, Year)

JUL 171998

7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 952 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month JULY 01:42 AM **Physician** Oscar L. Congreaves 15 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner MARYLAND HOSPITAL If Under 1 Yaar | If Under 24 Hrs. | 8 PRINCE GEORGES SOUTHERN 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2□ F Director YB 172216 B 63 Jan 8, 1935 Guyana, S.A. Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at England Surrey Wallington 1 XYas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? # 11 Royal Walk London Road SM67BS United Kingdom Funeral death 12. Was Decedant Ever in U,S. Armed Forces? 1 Yas 2 No If Yas, Giva Yaar or Dates: 13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Nevar Married 2 N Married 1 ☐ Yes 2 XNo Specify: Specify: Black þ 3 Widowed 4 Divorced "naturel", Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Corp Elamantary/Secondary (0-12) Collaga (1-4or 5+) Engineer British Broadcasting 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Nem Z7 is marked oth any linjury or other treumatic even Pates. F. Yaw Tryphena Congreaves 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SM67BS 19a. Informant's Name/Relationship (Type, Print) Thelma B. Congreaves # 11 Royal Walk, London Road, Wallington, England 20b. Place of Disposition (Name of cemetery, crematory or other place) July 24, 1398 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Wallington, England Bandon Hill 21. Signature of Funeral Service Licenses ne and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 les 23a. Part1. Enter the disease, or complications that ceused the heath. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final diseasa or condition resulting in daath) . HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Examiner Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Causa (Disaasa or Injury Due to (or as a consequence of) that initiated events resulting In death) Last Due to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? the Part 1. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part 1. signed by t 4 Unknown 1 Yes 2 No 3 Probably þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen s complation of cause of death? certificate has 1 ☐ Yes 2 ☐ No Physicien: 25. Was casa referred to medicel examiner? 1 Yes 2 No Be 26. Place of Death (Check only one) To Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatiant 2 DER/Outpatient 3□ DOA After this Data of Injury 28b. Time of injury 28d. Describe how Injury occurred Certification: 27. Manpar of Death 28c. Injury at Work? Attending 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datamined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 ☐ Homlcida 8 within 24 hours To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated edical Medical Examiner: On the basis of and mahiner stated (Check only one) mination and/or Invastigation, In my opinion, death occurred at tha time, date and place, and due to the causa(s) 8

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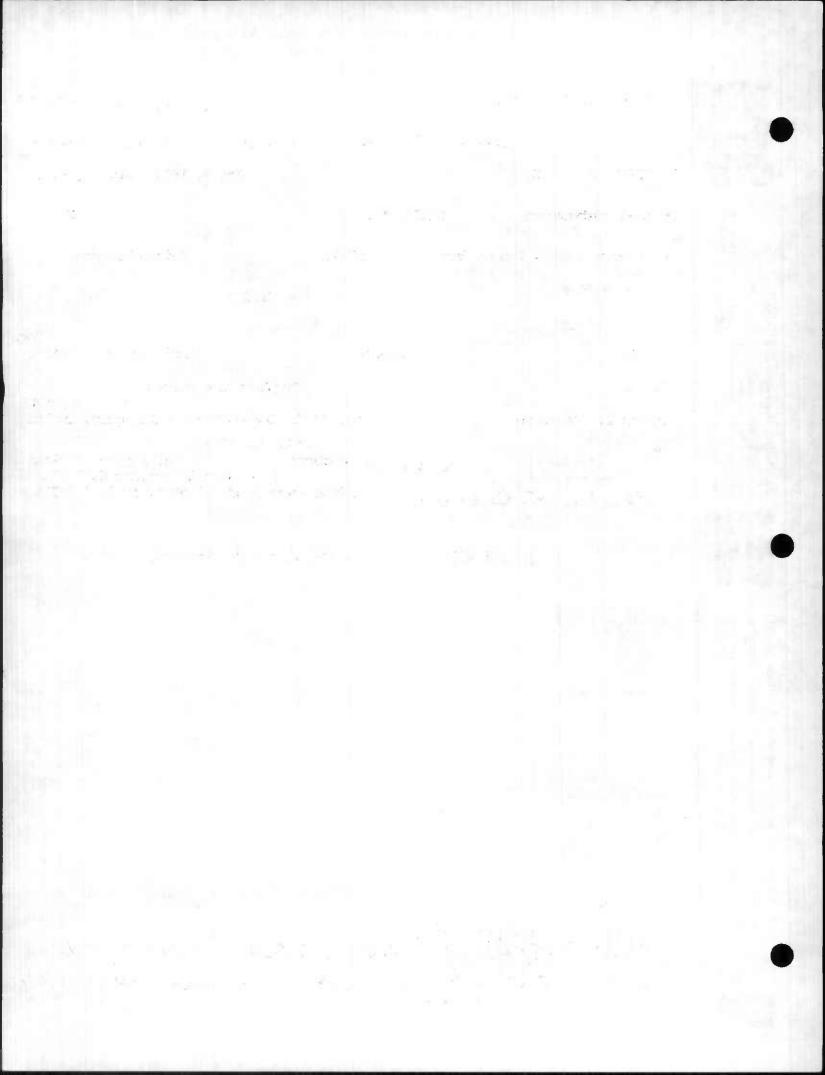
29d. Date signed (Month, Day, Year)

HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

Maryland 21215-0020

Records, P.O. Box 68760.

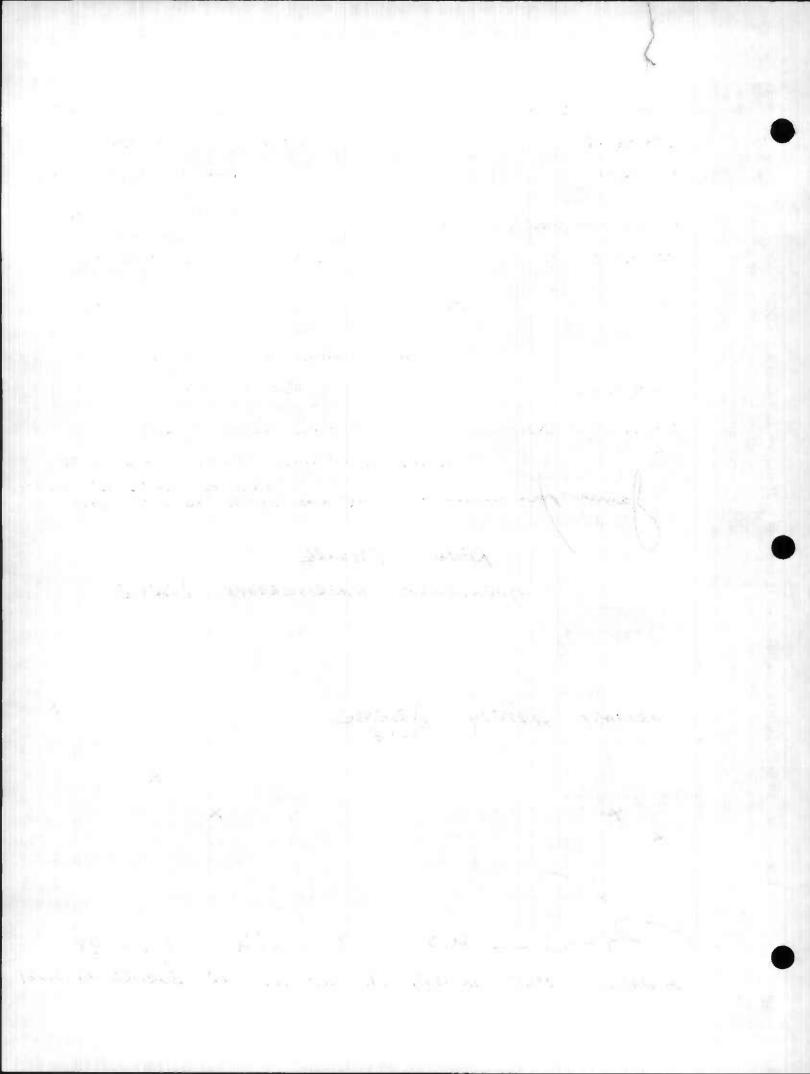
Division of Vital



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Robert J. Callahan 3:00 PM July. 10 1998 /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 1809 Reynolds Ct. Crofton Anne Arundel If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Yaer 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthpleca (Stata or Foraign Country) **Funeral** Months Deys 10XM 2□ F Yrs August 26 1920 Pennsylvania Director 173-07-6821 Usuet Residence of Decedent with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 16 Yas 2 No Director Maryland | Anne Arundel Crofton 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1809 Reynolds Ct. 21114 United States death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11 Marital Status after 1 Nay 2 No tf Yes, Give Year or Dates: 1942–45 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 1 Labor Union representative 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) 2 should be finand Mental H James E. Callahan Florence Shaffer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m 1809 Reynolds Ct. Crofton, MD
20b. Place of Disposition (Neme of cemetery, cremetory or other place) 21114 20c. Location - City or Town, Stete Jane S. Callahan/wife 20a. Mathod of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury o 7/14/98 Williamsport, PA Carmel of Wildwood 22. Name and Addrass of Fecility Robert E. Evans Funeral Home Inc. 21. Signature of Funeral Service Licensee 16000 Annapolis Rd. Bowie, MD 20715 Approximete Intervei Between Onset and Deeth plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, y one cause on each line. **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) Examiner ATHEROSCIEROTEL DESEASE Physician/Medical Examiner b. HYDERTENSIUM sician and burial-trans Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequença of) death certificate be execut Box 68760, as the Due to (or es a consequença of) resulting in deeth) Last 950 ō Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Pert I 23b. Did tobacco use contributa to the cause of death? detached 1 Yee 2 No 3 Probably 4 Ninknown à Division of Vital Records, p 24b. Were autopsy tindings aveileble prior to complation of causa of death? Completed 24a. Wes an autopsy page 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No Physician: 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 27. Manner of Deeth 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After Natural 5 Pending Invastigation 1 Yas 2 No 2 Accident the 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 6 Could not be determined 3 Suicida 28e. Pleca of Injury - At home, ferm, street, factory, office bullding, etc. (Specify) in by 4 Homicide Certifying Phyaician: To the best of my knowledge, death occurred at the time, dete end pleca, end due to the ceuse(s) end menner as stated.

2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and pleca, end due to the ceuse(s) and manner steted. edicai 29e. Certifier 29c. Licensa number 0 3 6 3 8 4 296. Signature and title of certifier 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Saile 106, GLEN BURNER, HD. 21061 OAKWOOI) B. BADRO 7845 of the observation of the second 31. Dete filed (Month, Day Year) State Registrar



State of Maryland / Der

29d. Date signed (Month, Day, Year)

JULY 11, 1998

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/Medical		John Way a Facility Name (II							-	Ab Ciby Tow	m or Le	JULY ocation of Deal		1998	of Death	07	00AM
Examiner							. F. D					JOBITOTI OF JOB				NDCT.	C
uneral		PRINCE G Social Security N		8. Sex	-	7. Age (In yrs		if Under				8. Date of Bi			9. Birthole		
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Office	2	0a. Method of Disp				20b.	Place of Disp cemetery, cr	position (Ner	ne of	ce)	1	Dete	20c. Lo	ocation -	City or Tow	m, Stat	е
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pleted by Physician/Medical Examiner	li do n	mmediete Cause (i sisease or condition esulting in death) Sequentially list con- tany, leeding to im- ause. Enter Under Cause (Disease or that initiated events esulting in death) L	Finel n ditiona, medicite riying injury ast	b. c. d.	A	Due to (or as a conse	equence of):	le of dyin	ven in Part I.	V&f.	23b. Did	I tobacco Yes 2 Yes 2 Yes 2	o uae con 2□ No	ntribute to 3 Probe 24b. Wer avai	Onset of the cause	use of death? Unknow osy findings ior to of cause
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Registrar

31. Date filed (Month, Day, Year) JUL 171998

s of person who completed cause of death (Item 23a) (Type, Print)

N LOCKE M 111 Pen

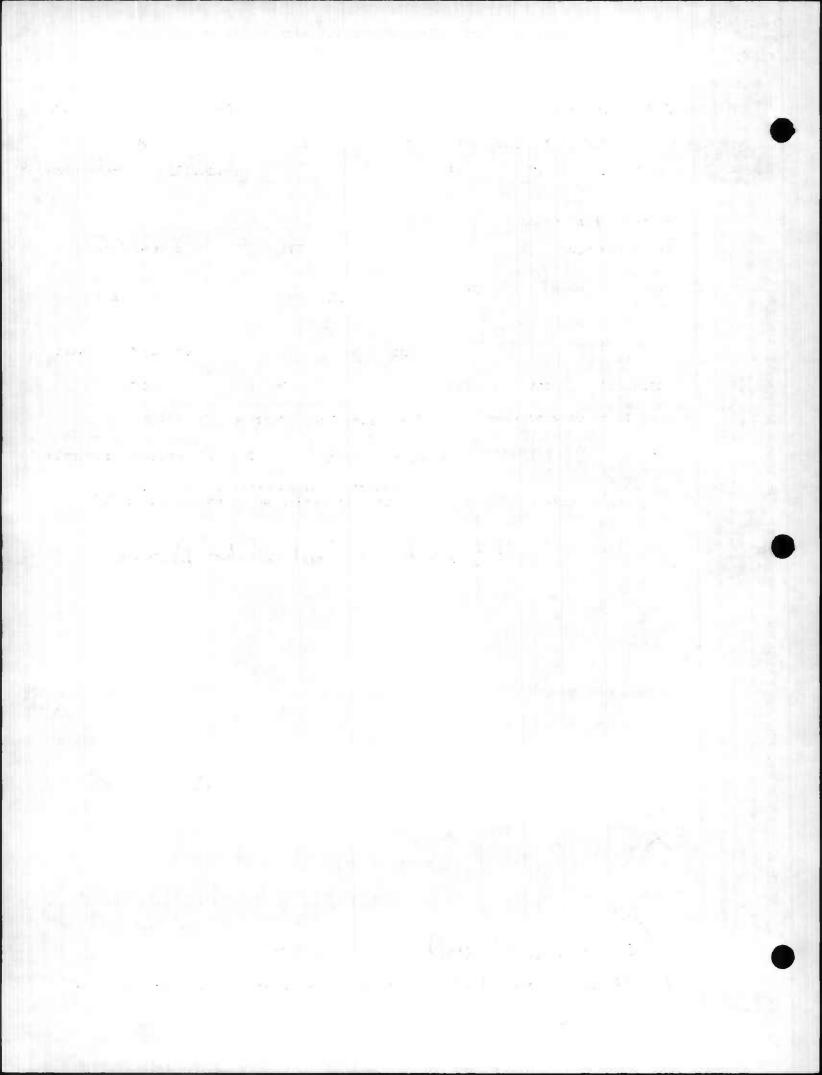
Day, Year)

32. Registrer's Signature

The state of the person of the 111 Penn Street, Baltimore, Maryland 21201

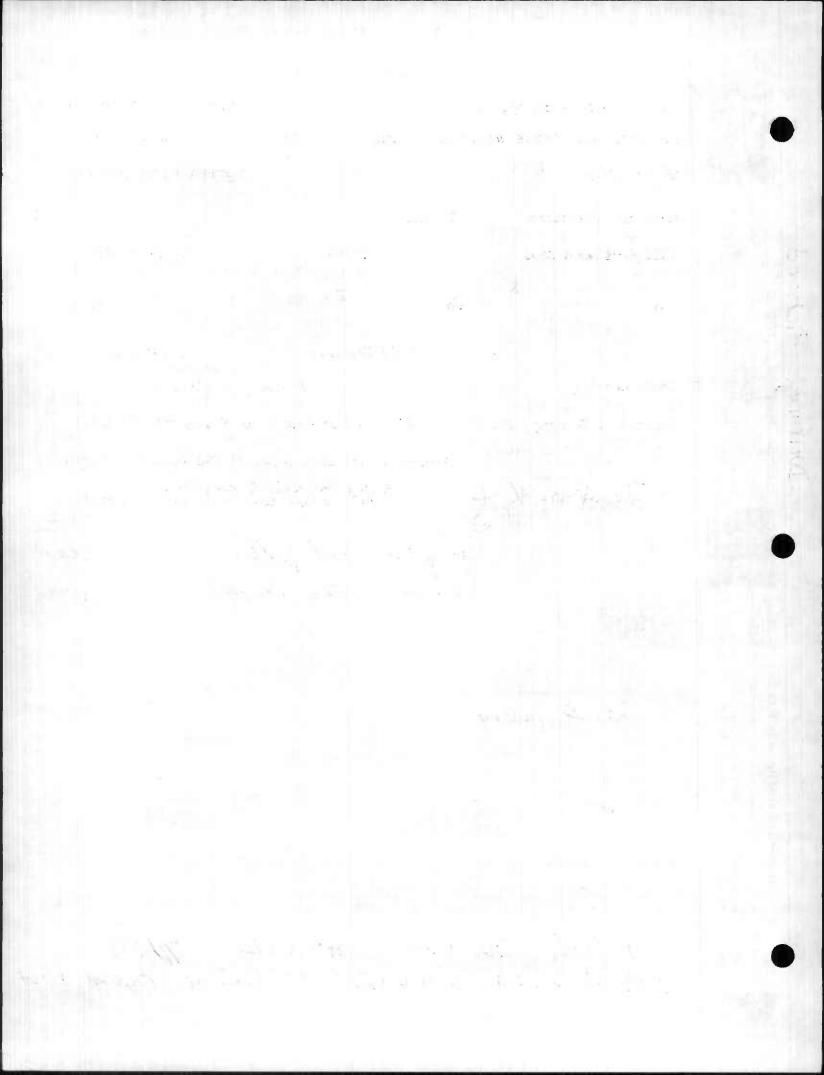
29c. License number

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State of Maryland / Department of Health and Mental Hygiene 98 2 1 9 5 5

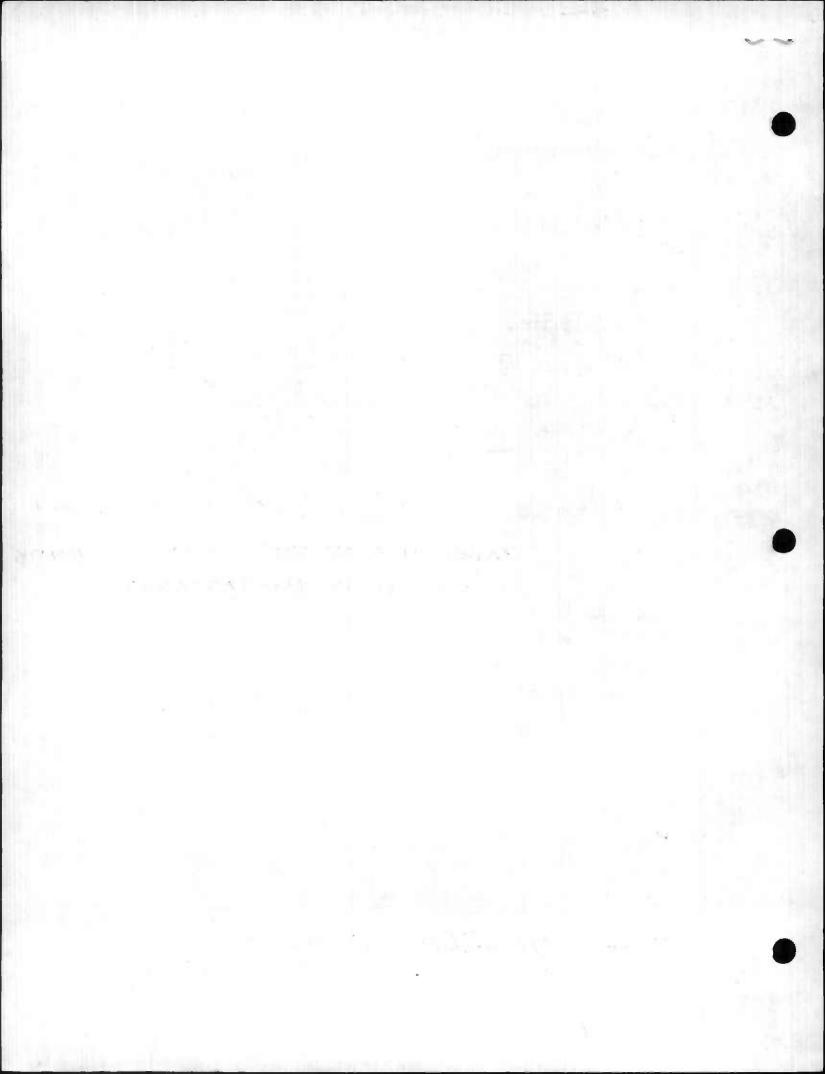
				Ce	rtificate	of L	Death		R	eg. No.	C.	130	
	. Decedent's Name (First, Middla, L	ast)							2. Date of Deal Month	th Day	Yaar	3. Tima o	of Death
sician edical	Richard Lewis Du	mning, Sr							JULY		1998	9:00	AM
miner 4	a Facility Name (If not institution, g	ive street and numb	er)			4	b. City, To	wn, or Lo	cation of Death	4c. Coun	y of Death		
	GREATER BALTI	MORE MEL	ICAL	CENT			TOWS			BALT	IMOR	E	
r	011-01-8963	Sex 7. 1 X M 2 □ F	Age (In yrs. 87	last birthday Yrs.	Months I	Yaar Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day September	Year) 1 1910		York	or Foreign
-	Jsuat Rasidanca of Decedant 0a. State 10b. County		10c. Cit	y, Town or L	ocation						1	Od. Inside C	City Limits
ŏ	Maryland Baltim	ore	1	rson									2 No
9	0e. Street and Number				10f. Zip C	ode			1	0g. Citizan of	What Coun	itry?	
ē	7310 Knollwood F			0 10	2128			-1-0 (0		United	State		
-	1. Marital Status 1. Never Married 2. Married 3. Widowad 4. Divorcad	12. Was Decede Armed Force 1 M Yas 2 If Yes, Give Yaar or Date	os? □ No	,S. 13.	was Decede If Yes, specify 1 ☐ Yes 2	-		gin? (Spe), Puarto	ecify Yes or No- Rican, atc.)		ack, White,		
	15. Decedent's l	Education rada completed)		(Give	edent's Usual of kind of work	done o	furina mosi	t of worki	na	16b. Kind of	Business/Inc	dustry	
Compieseo	Elementery/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use	retired)			047 0			
-		4		Civi	l Engi	nec				Oil Co			
Ď	7. Father's Name (First, Middle, Las	11)							(First, Middle,	ford	me)		
-	Lewis Dunning			1			Jess					0.11	
1	19a. Informant's Name/Relationship								A Route Number				
	Richard L. Dunni	ng, Jr.	20h P		osition (Neme	_	race	Lane	Balti	more,			
2	0e. Method of Disposition 1 Burial 2 □ Cramation 3	Removal from Sta	te C	emetery, cre	matory or oth	ar plac		1					b. 74
	4 Donation 5 Other (Spec	ify)	Du.		Valley 2. Name and	_			/18/98	Timoni	um, M	aryla	nd
sian/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to Immadiata cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	a c d contributing to deat	Due to (o	or as a conse	quence of):	la la la la la la la la la la la la la l	en in Pert)us	23b. Dld to	obacco use c	ontributa t	7 G Csc	o of death
	10-00	/ celure							1 🗆 Y	'es 25 No	3 ☐ Pro	bably 4[Unknow
									24a. Was a	an autopsy med?	CC	ere eutopsy vailable prior ompletion of death?	y findings r to causa
Completed									1 D Y	es 2 No	11	Yas 2	□ No
	25. Was case referred to medical		_				26. Place	e of Deat	h (Check only o	ne)		. 1	
0	axaminar? 1 ☐ Yas 2 ☐ No	Hospital:	atient 2	ER/Outpatie	ent 3 DOA	Oth	or.		ma 5□ Resid		ther (Special	fy)	1
Certification: T	27. Mennerof Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident invastigat	28a. Date of (Month,		28b. Time injury		c. injur Wor	y at k? Yas 2 🗆	No	28d. Describe h				
	3 Suicide 6 Could not determine	d 28e. Place of	Injury - At he etc. (Specif		treet, factory,	office			28f. Location (S City or Tow		nber or Run	e/ Route Nu	ımber,
		Physician: To the beaminar: On the basi and manne	s of examine										o(s)
	29b. Signetura and titta of certifier	2		-	29c.	Licens	e number			29d. Date sign	ed Month,	Day, Year)	
	A Nink	An	E	Acc		4)	870	92		7/17	168		
3	30. Name and address of person wh	o completed cause	of deeth (Item	n 23e) (Type	, Print)		-			1110)		
3	J. Kicely P.	O. FACO	1.	6 TN.	Chas	les	57	5.	ul 61	5 /	OGO N	H. 2	(204
	31. Dete filled (Month, Dey, Year)												



State of Maryland / Department of Health and Mental Hygiene

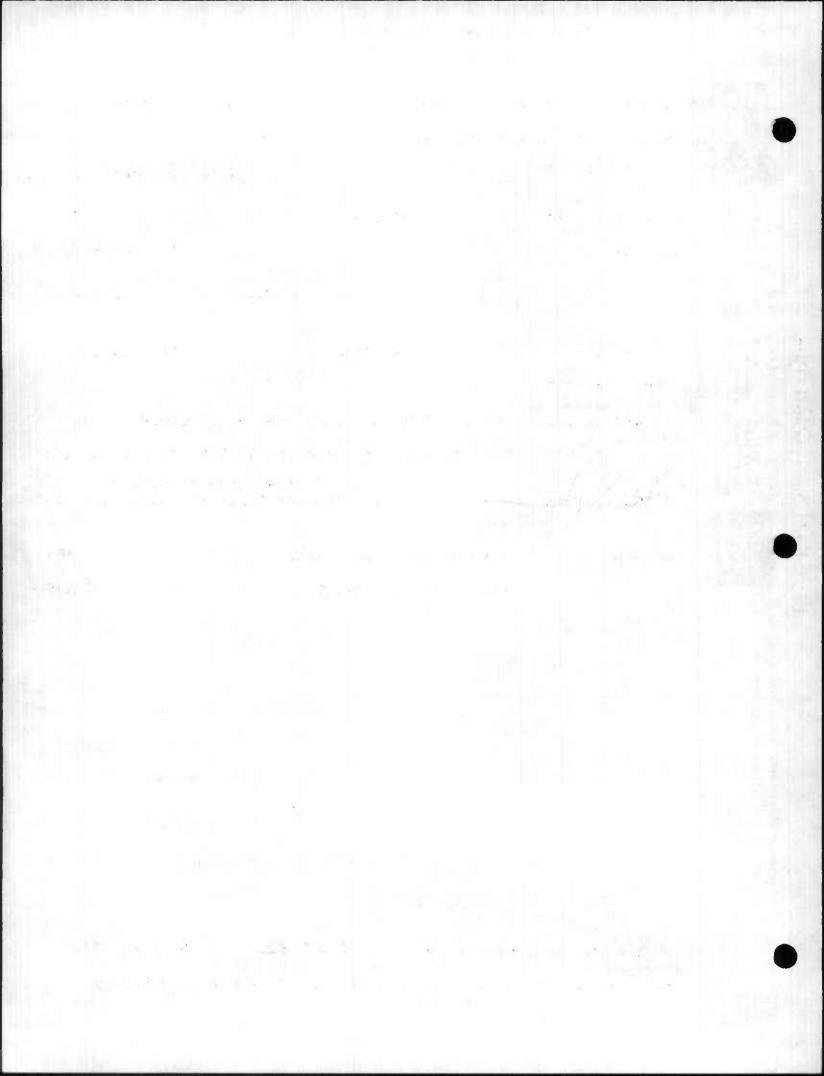
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					Certificate of Death	Reg. No.	121300
	Physicia	_	1. Decedent's Neme (First, Middle, Las	0.11	11.	2. Dete of Death Month Dey	3. Tima of Death
3,1	/Medica	al .	Pauline M	ary WiMa	141a	July 17 190	18 8:00AM
	Examine	er	4a Facility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Deeth 4c. County	of Death
_	Fundad		5. Social Security Number 6. Se	X J. Age (In yrs. la	st birthday) If Under 1 Year If Under 24 Hrs		9. Birthplace (State or Foreign
	Funeral Director			M 2DEF	3 Yrs. Months Days Hours Min	(Month, Day, Year)	Country)
Þ	1000		Usual Residence of Decedent			100019 10 11101	Time 9
aryle	a ho		10a. State 10b. County	10c. City,	Town or Location		10d. Inside City Limits 1 🗆 Yes 2 🗐 No
S S	188-1	Directo	Maryland Rall YV 10e. Street and Number	nore Pur	10f. Zip Code	10g. Citizen of W	
with	2 2		8820 11/0 Alle	O Blud	212311	109.01241011	1
death with the Maryland	78 20	Funeral	11. Merital Status	12. Was Decedent Ever in U,S	. 13. Was Decedent of Hispanic Origin? (\$		- American Indian,
_ 1	et, or tisms 23s or 28s-f show Examiner must be notified at	2	1 Never Merried 2 Merried	Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:		k, White, etc.
000 Dours	"naturel", or	d b	3 Widowed 4 Divorced	Yeer or Detes:	10 165 2 ps 110 Specify.	Specify.	VVVCL IT
1215-0020 within 72 hours after	natur	Completed	15. Decedent's Edi (Specify only highest grad	cation (e completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b. Kind of Bu	siness/industry
	the state of	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	hair stulist	Beauty	LI STOOL
-	other .	Be C	17. Father's Nemle (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maiden Sumam	9)
arylan	Mental arked o	2	Gaetano h	LeMartia	Rose	WINKHOUN	
lar 2 sh	and Mental Hygiena. Is marked other than raumatic event, the M		19a. Informant's Neme/Reletionship (T	/pe, Print)	19b. Meiling Address (Street and Number or R	ural Poute Number, City or Town,	Stafe, Zip Code)
- 6	of Heelth and Mental hyglena. Item 27 ia marked other than r other traumatic event, the M	-	ainda laylo	R NUCCEI	X 11 Lake Wood Rd.	Parkville, M.	d 21254
0 3	0 = 5		20a. Method of Disposition 1 ABurial 2 □ Cremetion 3 □ I	Removel from Stete	metery, crematory or other place)	July 20 Ballion.	City or Town, Stete
-	Department Important: I any Injury o	-	4 Donation 5 Other (Specify, 21. Signeture of Füherel Service Licens		22. Name and Address of Fecility	1948 DWHM	ORE MARYIANO
Balt Pemit.	Dep and Dep		du sola	5 1. 1.110	1 BOOM 1 LO 1 BOOM	varie Chapter	OT MEMORIES
		+	23a, Part1, Enter the disease, or comp	ications that caused the death.	Do not enter the mode of dying, such es cardia	c or respiretory errest.	Approximete
. Ph	ysician		shock, or heart feilure. List only o	ne cause on each line.			Interval Between Onset end Death
/ /N	Medical		Immediate Cause (Finel disease or condition	CARCIT	DIMA OF THE	COLON	2 WONTH
EX	aminer		resulting In deeth)	Due to (or	as a consequence of):	- A- J-IN	
3)	Examine		WITH.	LIVER ME	TASTASE	5
- No	14	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence of):		
68760,			that initieted events	Due to (or (es a consequence of):		
x 6876	ding phys	Medical	resulting in death) Last				
Box death cert				1			1
0. 8	ped hed	Physician	Part II. Other significant conditions co	ntributing to death but not result	ting in the underlying cause given in Pert I.	23b. Did tobacco use cor	tribute to the cause of death?
م ا	ed by the detached					1 ☐ Yes 2 12 No	3 Probably 4 Unknown
Records, P	88	d D				24e. Was an autopsy	24b. Wera autopsy findings
000	shou	900				performed?	available prior to completion of cause of death?
I Rec	has Se 2	Completed				1 Yes 2 No	1 Yes 2 No
			25. Wes case referred to medical		26. Place of De	eth (Check only one)	
of Vita Physician:	0 0	0	axaminer? 1 Yes 2 No	lospitel: 1 Inpatient 2 I E		lome 5 Residence 6 □Oth	er (Specify)
2 2	Ter I		27. Manner of Death 1 Metural 5 ☐ Pending	28a. Date of tnjury (Month, Day Year)	28b. Time of lnjury at Work?	28d. Describe how injury occurr	ed
Vision	Director: After 3 in by the fune	Car	2 Accident investigation 3 Suicide 6 Could not be	200 Diese of Joines At hou	M 1 Yes 2 No	28f. Location (Street and Numb	ne or Pural Pouta Number
Division or Attending	Direction	Certification:	4 Homicide determined	building, etc. (Specify)	ne, ferm, street, factory, office	City or Town, State)	or nurar noble ryumber,
Nospital or			29a. Certifier 1 Certifying Phy	sician: To the best of my knowl	edge, death occurred at the time, date and place	e, and due to the cause(s) and ma	nner as stated.
6 H	Pieter	edical	(Check only 2 Medicat Exami	ner: On the basis of examinetic end manner steted.	on end/or investigation, in my opinion, deeth occ	urred et the time, date and place, i	and due to the ceuse(s)
To the	Comp		29b. Signeture and title of certifier	50/	29c License number	29d. Date signed	(Month, Day, Year)
	1		tarsos q.	grund,	1919	July	17 1998
1			30 Name and address of person who o	opleted cause of death (Item 2	23a) (Type, Print)	11 1/1 2/22	, 1
			WK, FAUSTO AG 31. Date filed (Month, Day, Year)	32. Registral's Signatu	National Kal Tulky	IL, Ma 2123	+
	State Registra	# P		8 Julia Day	don-Randell		



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					State of Ma	aryıar				Death	vieritai n	Reg. No.	8 8	21957	
		Physicia		Decedent's Name (First, Middle, Last) Loraine Beatr		cki	ne				2. Date of D Month July	Day	Year	3. Time of Death	,
		* /Medica	al -	le Facility Name (If not institution, give		JUNI	115			4b. City, Town, or L	-		998 of Death	1:35 PM	1
		Examine	r	St. Elizabeth's		ng H	ome			Baltim	ore		N/A		
		Funeral Director	5	5. Social Security Number 6. Second 217-16-7031	7. Ag	90 (In yrs. 75	last birthda Yrs.	y) If Und Month	er 1 Year s Days		(Month, L	Sirth Day, Year) -1922	9. Birth Cou West	place (State or Foreigntry) Virgini	m ia
		pud * -	-	Usual Residence of Decedent 10e. State 10b. County		10c. Cit	ty, Town or	Location						10d. Inside City Limits	s
		Maryl H sho	M	Maryland N/A			Balt:	imore	9					1 X Yes 2 □ No	0
		th with the	5	10e. Street and Number 3210 Clarinda					ip Code 2 1 2 3	30		10g. Citizen of 1 United			
	5-0020	o','o	by Fur	11, Marital Status 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes ②☐ I If Yes, Give Year or Dates:		J,S. 13	3. Was Dec If Yes, sp 1 ☐ Yes		Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or to Ricen, etc.)	lo- 14. Rac Bla Specif	ck, White,	can Indien, etc. ite	
	15-0	"natural",	Completed	15. Decedent's Edu (Specify only highest grade	cation e com <i>pleted)</i>		16a. Dec	cedent's Us	ual Occu	upation e during most of work ed)	king	16b. Kind of B	usiness/Ir	dustry	
F	2121	within then the	dwo	Elementary/Secondary (0-12)	College (1-4or 5	5+)		velo		90)		Elec	tron	ics	
RAIM	Maryland 2	d 2 should be filed h and Mental Hygi 7 Is marked other traumatic event,	o Be C	17. Father's Name (First, Middle, Last) Elmer Davison						18. Mother's Nam Ethel	Gral	le, Maiden Suman 1 a M	ne)		
26	lary	shou and M s mari		19a. Informant's Name/Relationship (Ty						et end Number or Ru					
0		ges 1 and 2 t of Haalth If flem 27 I or other tra	-	Richard B. Dock	cins/Spc		3210 Place of Dis			ida Ave.	Balt:	imore, M)
Ĭ	altimore,	8 - 5 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Me	adow:	ridge	e Me	emorial	7/17/9	8 Dors	ey,M	aryland	
5	~ m 92F59			21. Silveture of Funity Service License	DE		1.0							ne 21227 ne,Maryla	
I		Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.											
CK	1.	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) A S P. RATION PREUMONIA Due to (or as a consequence of):											6 HRS	
0	-	D =	Musical Sciences											5 YEARS	
	,00	icate be axecuted physician and s the burial-transit	Exam	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	,	Due to (d	or es a cons	sequence o	f):				-		
	x 68760,		8	that initiated events resulting in death) Last		Due to (c	or as a cons	equence of	f):						
	Вох	attending for use a	Clan	Pert II. Other significant conditions cor	authorities an algorith to		veltice le the	a see alank da a		shan la Dart I	22h D	d tobago uga or	antelbusta (to the cause of death	h 2
	P.O.	ed by the detached	Phys	Pen II. Other significant conditions cor	tributing to death b	out not res	sulting in the	undenying) cause g	gven in Pert I.		□ Yes 2⊠No		obably 4 Unknow	
	Division of Vital Records,	88 P. 60 -	eted by		7						24e. W	as an autopsy rformed?	a	Vere autopsy findings vailable prior to ompletion of ceuse	,
	I Rec	The law ate has page 2:	Completed								10	∃Yes 2∭No		f deeth? ☐ Yes 2☐ No	
	Vita	s certificate director, pag	n i	25. Was case referred to medical examiner?	la anital.				10	26. Place of Dea					
	of	Physic this c	0	1 ☐ Yes 2 ☐ No 27. Manner of Death	fospital: 1 Inpatie		ER/Outpat		DOA			e how injury occu		(fy)	_
	ion	offing F ith. After e funer	ation	1 Natural 5 Pending investigation	(Month, De	y Year)	Injun		28c. Inj W	ork? ⊒Yes 2□No					
/-	Divis	after des Director d in by th	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Placa of Inj building, et			street, fact	ory, office	a	28f. Location City or	(Street and Num Town, State)	ber or Ru	ral Route Number,	
	F 1	Hospi 4 hou Funer tely fill		29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	elclan: To the best ner: On the besis o and manner st	f examine	owledge, de etion and/or	eth occurre investigation	ed at the on, in my	time, dete and placa opinion, deeth occu	, end due to the	ne cause(s) and m e, date and place,	anner as , and due	stated. to the cause(s)	
	la	To the To the comple		29b. Signeture and title of certifier	0	11		2		nse number		29d. Date sign	ed (Month	, Day, Year)	
4					Russe		0		D	30182		JULY	16,	1998	
			3	30. Name and address of person who co	mpleted cause of d				SENSO	IN AUT	BALTO	M02	122	7	
		State Registra		31. Date filed (Month, Day, Year) JUL 1 7 199	32. Regit	lie Lo	vidon	Gando D	2						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 09, MARGARET 7:50 AM DILLER JULY /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 098-14-4109 1 □ M 2 🗓 F 75 Yrs 09/19/1922 NEW YORK Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show 1 ☐ Yes 2 No Director CARROLL **ELDERSBURG** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with Hygiene.
Other than "natural", or items 23a or ent, me Medical Examiner must be it 5601 BARTHOLOW ROAD 21784 U.S.A. Funeral 12. Was Decadent Ever in U,S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHTTE P 3 Widowed 4 □ Divorced Yeer or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 7 is marked other treumatic event, 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file ment of Health and Mental Hy ant: If item 27 is marked oth jury or other treumatic even MATTHEW JOSEPH AHEARN MARY CECILIA McKEOGH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) CATHERINE R. HEALY/DAUGHTER 5601 BARTHOLOW ROAD ELDERSBURG, MD 21784 20h. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition BALTIMORE-WASHINGTON CREMATORY 1 ☐ Burial 2 A Cremation 3 ☐ Removel from State Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) 7/14/98 LAUREL, MD 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses STERLING ASHTON FUNERAL HOME, INC. ach 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. **Physician** ASPIRATION PNEUMONIA /Medical Immediate Cause (Final disease or condition resulting in death) Examine Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Lest Due to (or as a consequenca of): physician a P.O. Box 68760 8 Physician/Medicai Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 8 1 Yes 20 No 3 Probably 4 Unknown 6 Division of Vital Records. ģ 24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 □ Yes 2 □ No certificate 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Inpatient 2 No Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA this 27. Many fer of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural Attending 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 8 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. edical 29a, Certifie 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

RB Report National Property of the Party National Property of the Party National Property of the Party National Property

State Registrar 31. Date filed (Month, Dey, Year)
JUL 1 7 1998

30. Name and address of person

29b. Signature and title of

32 Registrer's Signature

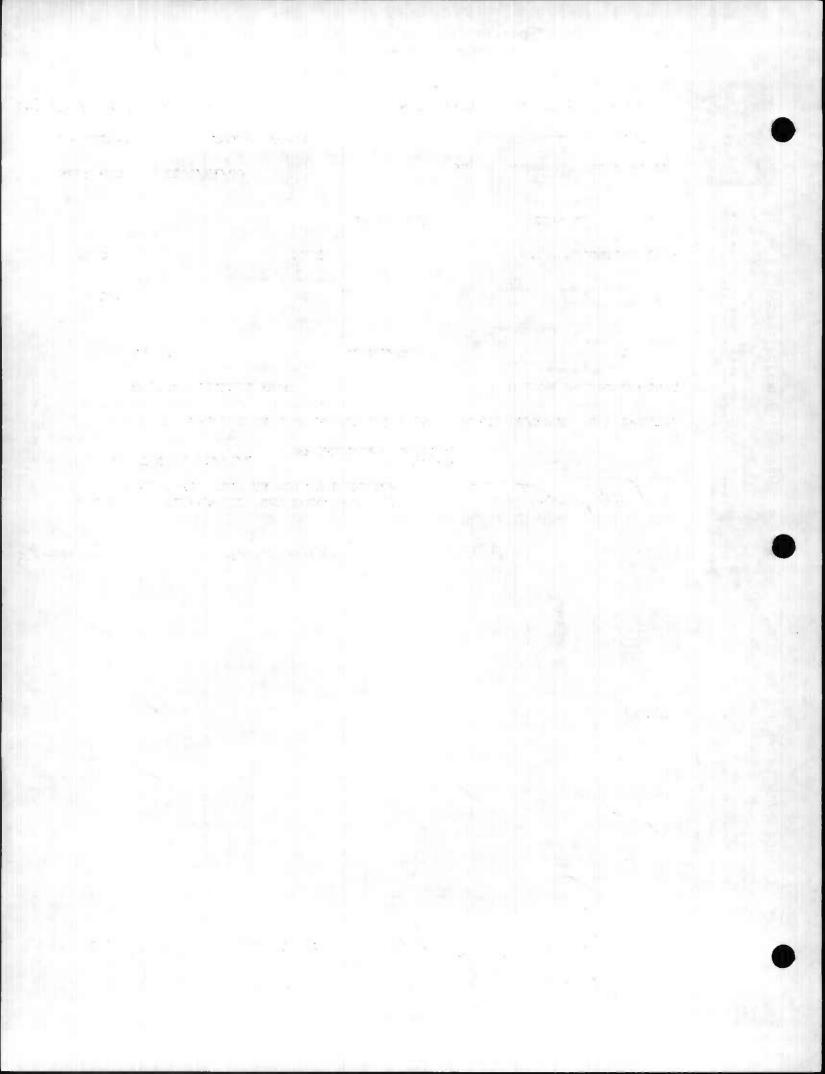
no completed tay se of death (Item 23a) (Typa, Print)

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10,1998



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	/land		10e. State 10b. County		10c. City, Town	or Location					10	Od. Inside City Limits
	Man	tor	MD	n/a		Baltim	ore					XXYes 2 No
	or 28	Director	10e. Street end Number			10f. Zip Co	-		10	g. Citizen of V	Vhet Coun	try?
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Baltimore,	permit. Pag Department Important: fi any injury o		21 Signature of Funeral Service L	loensee		James 7	A. 1	of Fecility Morton	& Sons	Fune	ral 1	Home
			23a. Pert Inter the disease, or of shock or heert failure. List of	complications that cause	d the death. Do n				- Balto		21	217 Approximete
J.	Physician		snoch or neert failure. List o	only one cause on each li	ne.						1	Onset end Deeth
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	To the Hospital or Att within 24 hours aftar d To the Funeral Direct completely filled in by	edical	29a. Cartifier 1 Certifying (Check only one) 2 Medicat E	Phyeician: To the best xaminar: On the bests of end mennar st	exeminetion end	daath occurred at t Vor Investigetion, in	he time, my opin	dete end plece, lon, deeth occur	and due to tha ce red et tha tima, da	use(s) end ma ita end plece,	nnar as st	ated. tha ceusa(s)
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			30. Neme and addrass of person w	no complated ceuse of d	leeth (Itam 23a) (Type, Print)						
			Kerron H. ELD	ER 2600	liberty	Hauts	B	aHimo	ore MI	7 212	15	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Death **Physician** Carl Allen Doney /Medical 4b. City, Town, or Location of Death 4c. County of Death 8:37pm 4e. Fecility Name (If not institution, give street and number) Examiner Doctors Community Hospital Lanham Hrs. Prince George's Co 6. Sex XXM 2□ F 7. Age (In yrs. lest birthday) 66 yrs. if Under 1 Year 8. Date of Birth (Month, Day, Year) Sept. 22, 1931 5. Social Security Number **Funeral** Days Hours Pennsylvania Director 205-26-1347 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified as Maryland Prince George's Bowie Maryes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12400 Sandal Lane 20715 United States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 StYes 2 No
If Yes, Give
Year or Dates: 1952-54 1 Never Married 2 Married 1 ☐ Yes 3 No Specify: White by Specify: 3 ☐ Widowed 4 ☐ Pivorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be h end Mentai F William Edward Doney Elsie Kisthardt 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Heelth er. Important: If Item 27 Is n any Injury or me. Brian Doney/son 12400 Sandal Lane Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 7/17/98 Waldorf, MD Hunte Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home Inc. 21. Signature of Funeral Arvice 19 16000 Annapolis Rd. Bowie, MD 23a. Part1. Enter the disease, or complications that cause one death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Approximate Interval Betw Onset end Death **Physician** /Medical Immediate Cause (Finel LOWER GASTROLNTESTINAL HEMORRHAGE diseese or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner 10 YEARS DIVERTICULOSIS The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): signed by the e Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? O 1 Yes 2 No 3 Probably 4 Unknown o. of Vital Records, by 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? Completed 1 ☐ Yes 2 ☐ No certificete Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this Certification: 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Division After Natural 5 Pending investigation 1 Tyes 2 No 2 Accident efter death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 6 To the Hospital or within 24 hours eff To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and manner es steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medicai (Check only one)

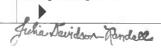
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31. Dete filed (Month, Dey, Yeer) State Registrar

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MAMMETT

29b. Signature and title of certifier

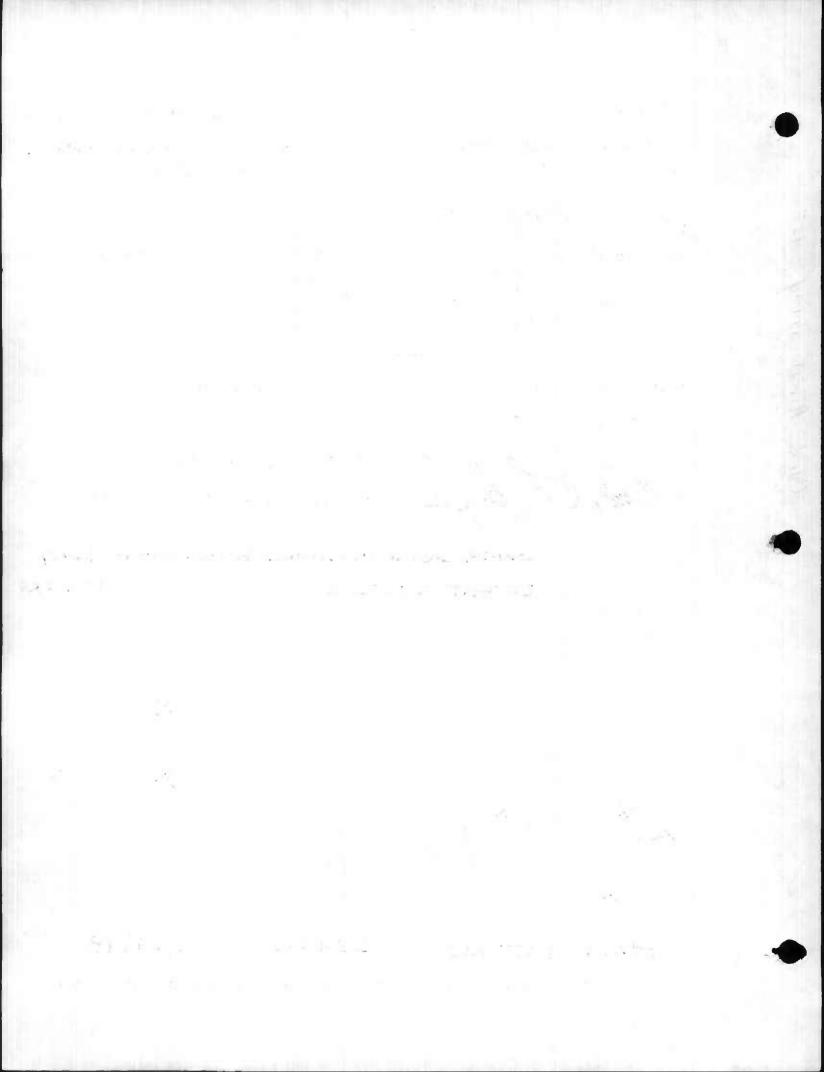


29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

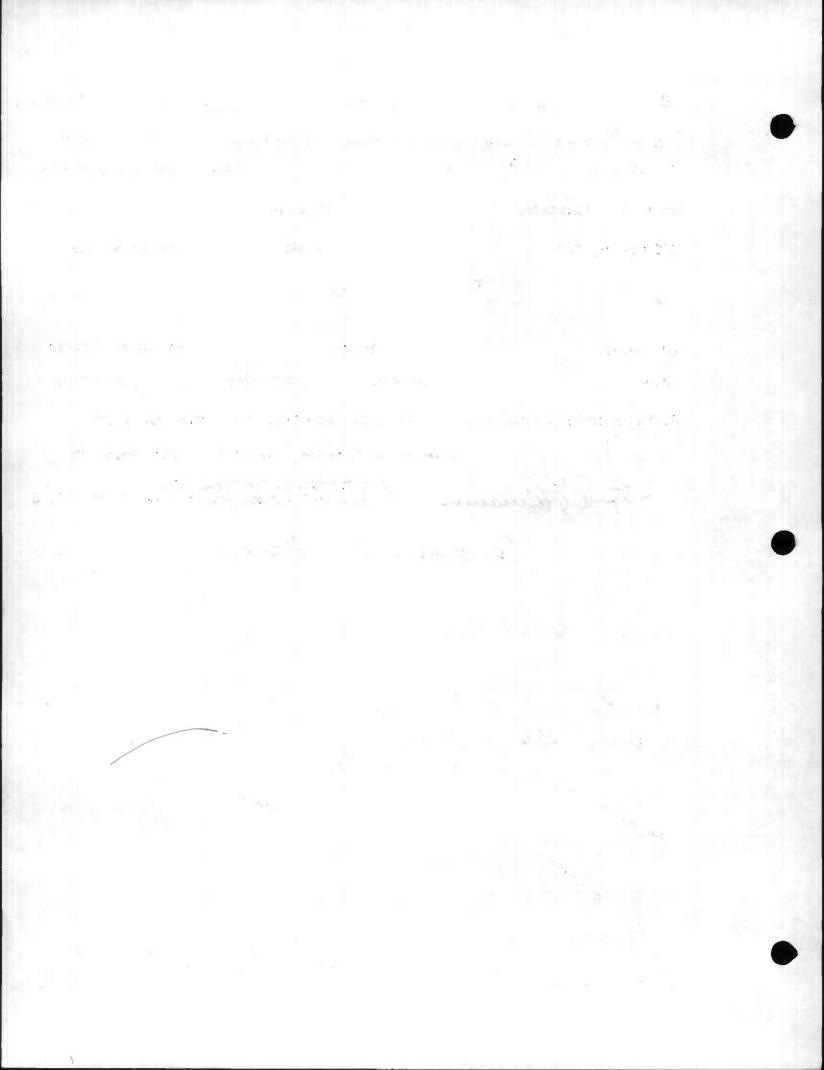
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DR CAROLYN HAMMET T, 5268 DAWES AVENUE, ALEXANDRIA, VA 223/1



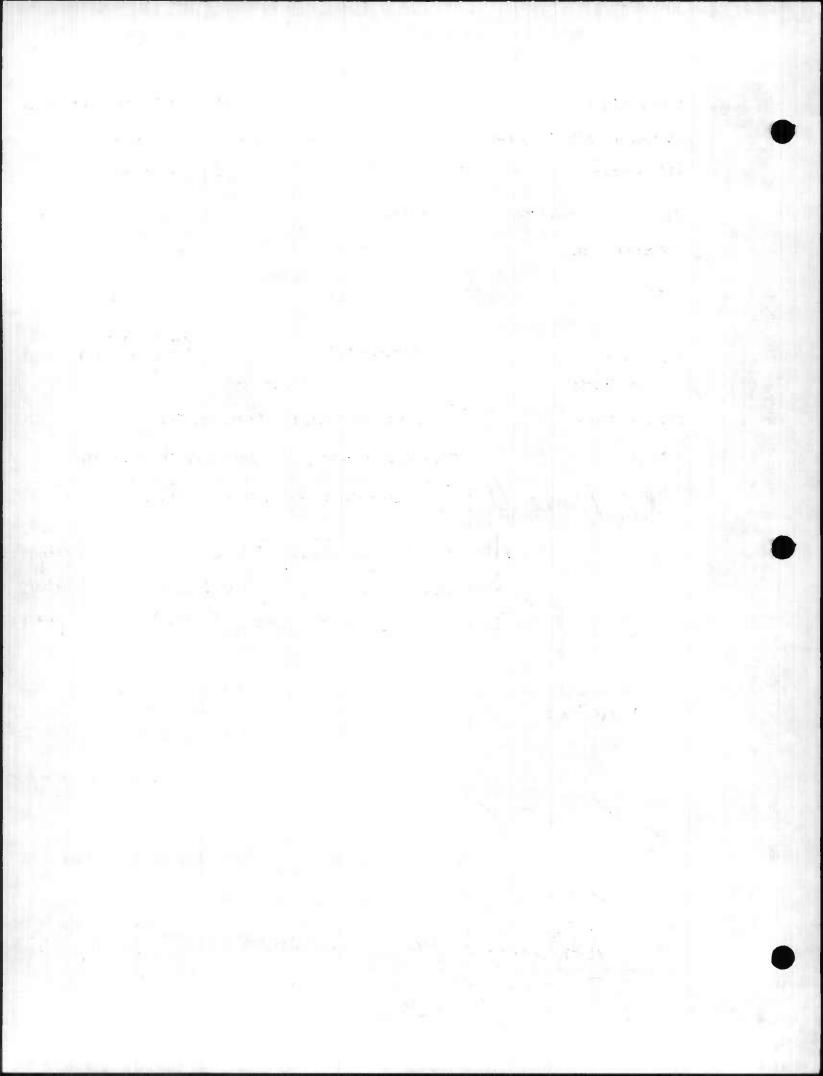
State of Maryland / Department of Health and Mental Hygiene 8 2 | 96 |

			Certificate of	Death	Re	g. No.	
	Decedent's Name (First, Middle, Last)				2. Data of Deat Month	h Day Year	3. Time of Death
Physician /Medical	ANN CECEL	IA	FRAZIER		Jury	16 1998	8:15 AM
Examiner	4a Facility Name (If not institution, give stree			4b. City, Town, or Lo	cation of Death	4c. County of Death	
	PERRING PARKWAY CE	NTER GENESIS	ELDERCARE	PARKVIL	LE	BALTIN	LORE
Funeral	5. Social Sacurity Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Year Months Days	If Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	placa (Stete or Foreign ntry)
Director	019 12 1619	2XIF 98	Yrs.	294	Feb. 2,	1900 Massa	achusetts
pu *	Usual Residence of Decedent 10a. State 10b. County	10c City To	own or Location				10d. Inside City Limits
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ofter deeth with the Mei r items 23s or 28s-f si siner must be notified Funeral Director	325 Roxbury Court		10f. Zip Coda	21085	11	Og. Citizen of What Cou United Sta	
by by	1 Never Married 2 Married 1	Vas Dacedant Evar In U,S. med Forces? ☐ Yes (A)No Yas, Give ear or Dates:	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yas ♣₩No		city Yes or No- Rican, atc.)	14. Race - Ameri Black, Whita, Specify:	
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d 2 should be filled within and Mental Hygiene. This marked other than traumatic event, the Me	John	M	acPhee	Christi		•	cnown)
shou man	19a. Informant's Name/Relationship (Type, F	Print) 1	9b. Mailing Addrass (Street	end Number or Rura	I Route Number	City or Town, Stata, Zi	p Coda)
1 and 2 Heelth a em 27 is	Jo-Ann Hotchkiss / I	aughter	4110 Souther	rn Ave., I	Baltimor	e, MD 2120	06
of He of He of He	20a. Method of Disposition		of Disposition (Neme of stery, crematory or other ple	ce)	Date	20c. Location - City or T	own, State
Pag nent int: It	1 ☐ Burial 2 🖾 Cramation 3 ☐ Ramo 4 ☐ Donation 5 ☐ Other (Specify)	valifom State	Mount Crema		7/98	Baltimore	, MD
permit. Departmimportal eny inju	21. Signature of Funeral Service Licenses		CAFA Stepl	hen D. Lol		.A. altimore, N	4D 21286
THE REAL PROPERTY.	23a. Part1. Enter the disease of complication shock, or heart failure. List only one car	ns that caused the death. Duse on each line.					Approximate Interval Between
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/Medical Examiner	Immediate Cause (Final disease or condition resulting in daath) a.	Seleson	asulas	diseo	a e	A	years
OCCUPANT OF THE PARTY OF THE PA	resulting in dealth)	Dua to (or as	a consequanca of):				0
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execu in end iel-tra	Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death Last	Due to (or as	a consaquance of):				
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T EF P	1 Yes 2 Hospi	1 Inpatiant 2 EHV	Outpatient 3LI DOA	har: 4 Harsing Ho		enca 6 Other (Spec ow injury occurred	ify)
Attending Physician: or death. ector: After this certificial by the funeral director, iffication: To Be (I garratural o Caronaling	Ba. Data of Injury (Month, Day Year) 281	b. Time of 28c. Injury Wo	rk? Yes 2□No	200. Describe in	ow injury occurred	
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e EPRO	4 Homicide datermined	building, atc. (Specify)	, iaiiii, street, iactory, omce		City or Town	n, Stete)	
To the Hospital or Attending P within 24 hours ster death. To the Funeral Director: After it completally filled in by the funeral Medical Certification:	(Check only 2 Medical Examiner:	n: To the best of my knowled On the basis of examination					
Mec	29b. Signature and title of contilier	and manner stated.	29c. Licen	sa number	2	9d. Date signed (Month	, Day, Year)
2 4 4 4	MM 's	0' 297	ns	202 -1)	7/17	166
	20 1/20 2/2	ded anion of death the con-	a) (Time Print)	8718	95	////	78
	30. Name and addrass of person who comple	PATRICI	a) (Type, Print)	SHA	POOP	BACT. A	GARYCA
State Registrar	31. Data filed (Month Day, Wall 1998	32. Régiftrar stélonature	n-Gandall			263	£ , '



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** July 5, 1998 10:22p.m. Freida Fisher /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Baltimore Northwest Medical Center Randallstown If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) If Under 1 Year 5 Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign
Country) **Funeral** Months Days 1□ M XXF 214-44-5598 51 Yrs Director July 10, 1946 Usuel Residence of Decedent 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Md. Baltimore Woodlawn 1 ☐ Yes 20No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21207 2 Retinue Court USA 12 should be filed within 72 hours effer death in and Mentel Hygiene. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indien 11. Maritel Stetus Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Security Elementery/Secondery (0-12) College (1-4or 5+) Computer Aide Administration 12th Grade 18. Mother's Name (First, Middle, Malden Sumeme) 17. Fether's Neme (First, Middle, Last) William Fisher Thelma Dorsey 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Sister permit. Pages 1 and 2 Department of Health a Important: If hem 27 is Marilyn Davis 2 Retinue Court Woodlawn, Md. 21207 Baltimore 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Buriel 2 Cremetion 3 Removal from State
4 Doyation 5 Other (Specify) ŏ July 9 Carpenters Cemetery Baltimore, Md. 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 21. Signature of Funeral Syrving Licensee Perty-Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Approximete Intarval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner physicien and the bunel-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest certificate be exec Box 68760, Physician/Medical use es t Pert II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yee 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy Completed pege 2 hes 1 ☐ Yes 2 ☐ No 1 Yes 2 D certificate Attending Physician: 25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only one) Be Hospitel: 1 Impatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 28h. Time of 28c. Injury et Work? edical Certification: After 5 Pending flours lifter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end manner es stated.
2 Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner steted. 29a. Certifier (Check only one) To the To the To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ampleted chise of deeth (Item 23e) (Type, Print) IMPERIM 31. Dete filed (Month, Day, Year) State Registrar

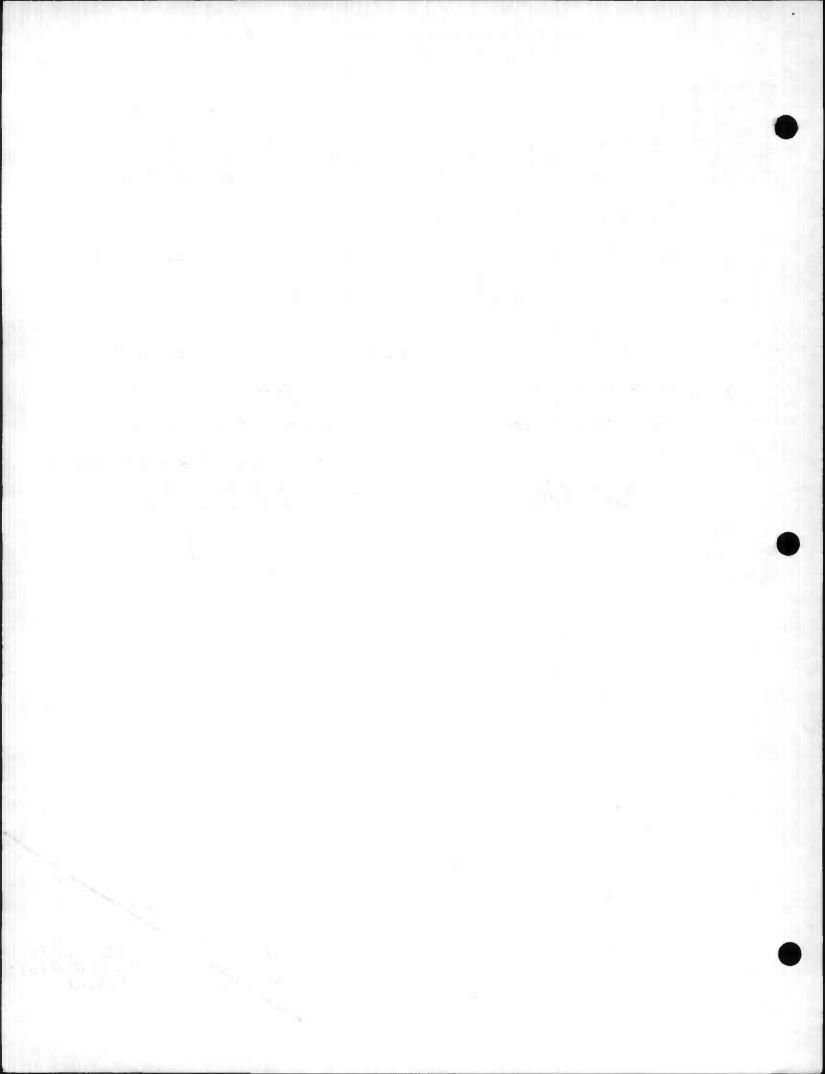


State of Maryland / Department of Health and Mental Hygiene 💚 🖔 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** TREGG 4b. City, Town, or Location of Deeth ANNA 130Pm 1998 /Medical 4a. Fecility Name (If not institution, give street end number, 4c. County of Death **Examiner** Good Samaritan Hospital N/A Baltimore If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth
Mours Min. (Month, Dey, 5. Sociel Security Number 6. Sex Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1□ M 2XF 75 216-28-2552 Yrs. December 22 1922 Mary Land Director Usual Residence of Decaden the Maryland 10a Stele 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinet must be notified at Maryland N/A 1 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5108 Craig Avenue 21212 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decadent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 2 should be filed within 72 hours efter on and Mentel Hygiene. Is marked other than "natural", or ftar 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify ģ 3 ☐ Widowed 4 ☐ Divorcad Black Completed 15. Decadent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Domestic Worker Private Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Marion Edward Scott Cordelia 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zlp Code) permit. Peges 1 end 2 st Depertment of Health and Important: If item 27 Is n any injury or other traun Anne L. Gaither/Daughter 5108 Craig Avenue Baltimore, Maryland 21212 20a. Method of Disposition

1 Burial 2 Cremetion 3 Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 7-16-98 King Memorial Park Woodlawn, Maryland 22. Name and Address of Fecility Mitchell-Wiedefeld Home, Inc. teven (. Ottle 6500 York Road Baltimore, MD 21212 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) · Cardio Genick shock secondary to Pulmoney Eucola Examiner Due to (or es a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initioted events resulting in death) Last Due to (or as a consequence of): physician of the buriel-t Box 68760 Physician/Medical Due to (or es e consequence of) use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? s been signed by the should be detech-1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed has 1 Yes 2DNo 1 Yes 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 Inpatient 1□ Yes 22 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 ER/Outpatient 3 DOA 10 funeral 28a. Date of Injury (Month, Dey Yeer) 27. Menne of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Injury et Work? After Certification: 5 Pending investigation death. 1 Yes 2 No for Attandi after death Director: A d in by the f 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homlcide To the Hospital o within 24 hours af To the Funeral Di completely filled is Cartifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number driana 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Good Sangziten Hogrital. 5601 Wah Recvin Andrade Adriana 31. Date filed (Month, Dey, Year) State Registrar

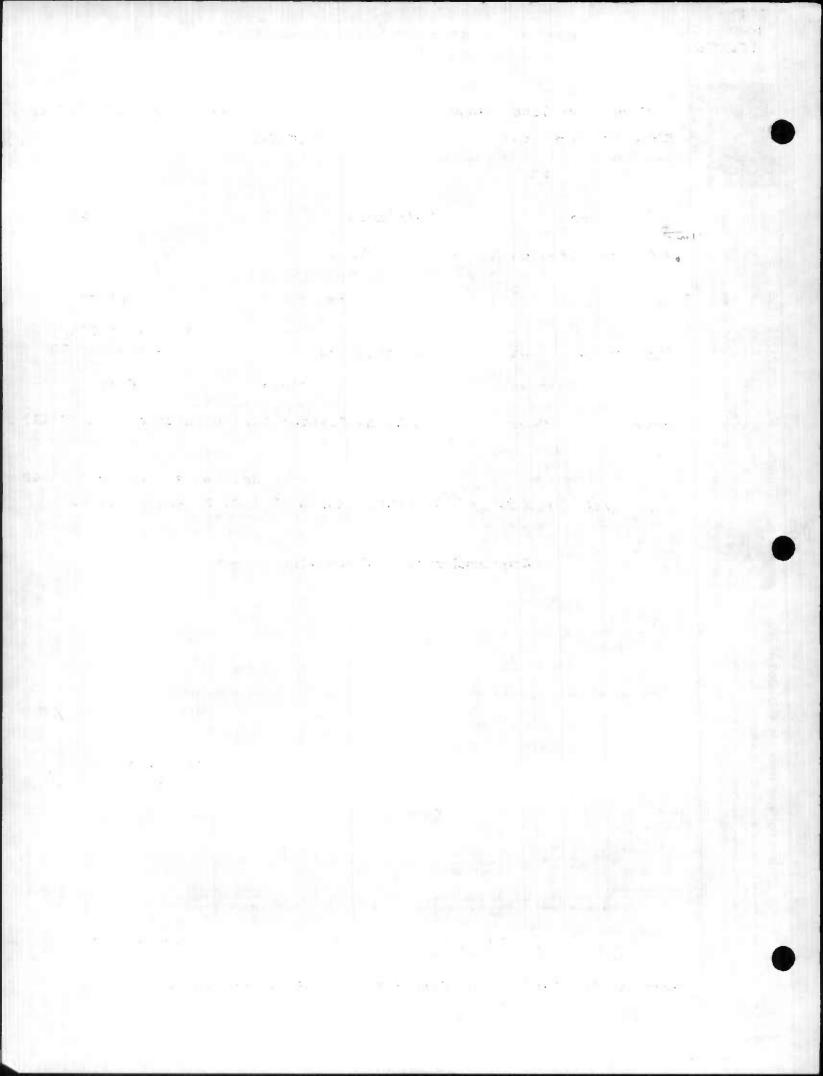
DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Q 2

Funeral Director Social Security Number 243-32-6513 S. Sex 2 F	4b. City, Town, or Local BALTIMORE		ey Year 3. Time of Death 13, 1998 0905 AM C. County of Death NA
Pleas William Gray 4a Facility Name (if not Institution, giva street and number) JOHNS HOPKINS HOPKINS HOPKINS HOPKINS HOSPITAL 5. Social Security Number 243-32-6513 1. Martlal Status 10b. County 10c. City, Town or Location Baltimore 10f. Zip Code 21213 1. Martlal Status 1. Martl	4b. City, Town, or Local BALTIMORE	JULY stion of Death 40	13, 1998 0905 AM c. County of Death NA
Supplied of the part of the	If Under 24 Hrs. 8. Hours Min.	B. Date of Birth (Month, Day, Year 07-01-3	9. Birthplaca (Stata or Foreign Country) NC
10a. State 10b. County 10c. City, Town or Location Baltimore			
Elementary/Secondery (0-12) 12th Grade 17. Father's Nama (First, Middla, Last) Unknown 19e. Informent's Name/Relationship (Type, Pnht) Mary Queen 20a. Method of Disposition XX Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address WM.C. Mary Physician //Medical Examiner Physician //Medical Examiner Iffe. DO NOT use retire Maintenance Maintenance Maintenance Maintenance Unknown 19e. Informent's Name/Relationship (Type, Pnht) Ary Queen 2207 E. Pre 20a. Method of Disposition XX Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address WM.C. Mary 23a. Part 1. Enter tha disaasa, or complications that causad tha daath. Do not anter the mode of dyis shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Bury 20a. Method of Disposition XX Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address 23a. Part 1. Enter tha disease, or complications that causad tha daath. Do not anter the mode of dyis shock, or heart failure. List only one cause on each line. Physician //Medical Examiner Due to (or as a consequence of):			100 - 10 00 10 0
Elementary/Secondary (0-12) 12th Grade 17. Father's Nama (First, Middle, Last) Unknown 19e. Informent's Name/Relationship (Type, Pnht) 19e. Informent's Name/Relationship (Typ			10d. Inside City Limits XIXYas 2□ No
Elementary/Secondery (0-12) 12th Grade 17. Father's Nama (First, Middla, Last) Unknown 19e. Informent's Name/Relationship (Type, Pnht) Mary Queen 20a. Method of Disposition XX Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 20a. Method of Disposition XX Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22a. Part 1. Entar tha disaasa, or complications that causad tha daath. Do not anter the mode of dyis shock, or heart failure. List only one cause on each line. Physician //Medical Examiner Iffe. DO NOT use retire Maintenance Maintenance 19b. Malling Address (Street 2207 E. Pre 20a. Method of Disposition XX Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address WM. C. Mar 23a. Part 1. Entar tha disaasa, or complications that causad tha daath. Do not anter the mode of dyis shock, or heart failure. List only one cause on each line. 23a. Part 2. Entar tha disaasa, or complications that causad tha daath. Do not anter the mode of dyis shock, or heart failure. List only one cause on each line. 2an Part 2. Entar tha disaasa, or complications that causad tha daath. Do not anter the mode of dyis shock, or heart failure. List only one cause on each line. 2an Part 3. Entar tha disaasa, or complications that causad tha daath. Do not anter the mode of dyis shock, or heart failure. List only one cause on each line. 2bue to (or as a consequence of):		10g. C	citizen of What Country?
Elementary/Secondery (0-12) 12th Grade 17. Father's Nama (First, Middla, Last) Unknown 19e. Informent's Name/Relationship (Type, Pnht) Mary Queen 20a. Method of Disposition XX Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address WM.C. Mary Physician /Medical Examiner Physician /Medical Examiner Iffe. DO NOT use retire Maintenance Maintenance Maintenance Maintenance Unknown 19e. Informent's Name/Relationship (Type, Pnht) 19b. Malling Address (Street) 2207 E. Pre 20a. Method of Disposition XX Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address WM.C. Mary 23a. Part 1. Entar tha disaasa, or complications that causad tha daath. Do not anter the mode of dyis shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Bury 20a. Method of Disposition XX Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address 23a. Part 1. Entar tha disaasa, or complications that causad tha daath. Do not anter the mode of dyis shock, or heart failure. List only one cause on each line. 23a. Part 2 Entar tha disaasa, or complications that causad tha daath. Do not anter the mode of dyis shock, or heart failure. List only one cause on each line. 24a. Donation 5 Due to (or as a consequence of):	dispantc Ortgin? (Specifican, Mexican, Puerto Ric Specify:	ify Yas or No- can, etc.)	14. Race - American Indian, Bleck, White, etc. Specify: Black
17. Father's Nama (First, Middla, Last) Unknown 19e. Informent's Name/Relationship (Type, Pnht) 19e. Informent's Name/Relationship (Type, Pnht) Mary Queen 20a. Method of Disposition XM Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address WM.C. Mary 23a. Part 1. Entar tha disaasa, or complications that causad tha daath. Do not anter the mode of dyis shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Arteriosclerotic Cardiovas Due to (or as a consequence of):	during most of working d)	Bal	Kind of Business/Industry Itimore City ecreation Ctn.
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemafary, crematory or other plate of Disposition 20b. Place of Disposition (Name of cemafary, crematory or other plate of Disposition 20b. Place of Disposition (Name of cemafary, crematory or other plate of Disposition 20b. Place of Disposition (Name of cemafary, crematory or other plate of Disposition (Name of cemafary, crematory or other plate of Disposition (Name of cemafary, crematory or other plate of Disposition (Name of cemafary, crematory or other plate of Disposition (Name of cemafary, crematory or other plate of Disposition (Name of cemafary, crematory or other plate of Disposition (Name of cemafary, crematory or other plate of Disposition (Name of cemafary, crematory or other plate of Disposition (Name of Cemafary, crematory or other plate of D	18. Mother's Name (F	First, Middle, Maide	on Sumama)
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XM Burial 2 Cremation 3 Ramoval from Stata Cematary, crematory or other plate	ston Str	eet Balt	timore, Md.21213
Physician //Medical Examiner 23a. Part 1. Entar tha disaasa, or complications that causad tha daath. Do not anter the mode of dyis shock, or heart failure. List only one cause on each line. Physician //Medical Examiner Immediate Cause (Final disease or condition resulting in deeth) a. Arteriosclerotic Cardiovas Due to (or as a consequence of):	ce)		Location - City or Town, Stete Md. -98 Owings Mills
b. D	ng, such es cardiac or r	respiratory arrest,	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceusa (Disease or Injury thet inititeled events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Dua to (or as a consequence of):			
d	van in Part I.	23b. Did tobacc	co use contribute to the cause of death?
Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given by the state of the state o			2 No 3 Probably 4 Unknown
Part II. Other significant conditions contributing to death but not resulting in the underlying cause give the state of th		24a. Was en eut performed? Inspec	evallable prior to completion of cause of death?
25. Was case referred to medical examiner? Hospitel:	26. Place of Death ((Check only one)	
O & E 27 Manner of Death 28s Date of Injury 28th Time of 28c Injury	4 U Nursing Home	e 5 Residence 3d. Describe how inj	6 ☐Other (Specify) iury occurred
1 Natural 5 Pending (Month, Day Year) Injury Wo to see the second of the	Yes 2□No		and Number or Rural Route Number,
29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time (Check only 22 Medical Examiner: On the besis of axamination and/or investigation, in my of			
Mouprite Are Youll OCME		29d. D JUL	Date signed (Month, Day, Year) LY 13, 1998
30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Bal State 31. Dete filed (Month, Day, Year) 32. Registrar's Signature			

JUL 17 1998



Ple	ase Type or	Print I	n Black	Ind	elible	Ink	. Assu	ire A	II Copie	s A	re Legi	ble.	
	State	of Mary	rland / De				Health a Death		lental Hy		ene 8	2	1965
1. Decedent's Name (First, Midd	dle, Last)								2. Date of D				3. Time of Death
HELEN MAE GRES	SHAM								Month	1	2. 19°	Year 98	12:15M
4a Facility Name (If not Institution	on, give street and n	um <i>ber)</i>					4b. City, To	wn, or L	ocation of bea	-	4c. County	of Death	
ST. ELIZABETH'	S HOME						BALTI	MORJ	E	-	N/A	A	
5. Social Security Number 213-34-1797	6. Sex 1 □ M 2 1 F	7. Age (In	yrs. last birthd 88 Yrs	July	If Under 1 Months [Year Days		24 Hrs. Min.	6. Date of B (Month, D 05/17/	Day, Y	Year)	9. Birth	nplace (State or Foreign intry) RYLAND
Usual Residence of Decedent													
10a. State 10b. Count	У	100	c. City, Town o	r Loca	ition								10d. Inaide City Limits
• MD HOWA	ARD		EI	LLI	COTT	CI	ГY						1 ☐ Yes 2 ☐ No
ive. Street and Number					10f. Zip C	ode				100	g. Citizen of V	What Cou	intry?
3004 NORTH RID	DGE ROAD				21	043	3					U.	S.A.
11. Marital Status		cedent Ever	in U,S.	13. W	as Deceder	nt of I	Hispanic Ori	gin? (Sp	pecify Yes or No Rican, etc.)	10-		ce - Ameri	ican indian,
1 Never Married 2 Ma	Armed F	2 XNo							Hican, etc.,				
3 Widowed 4 Divorce	ed Year or I	Dates:		16	Yes 20	X NO	Specify:				Specin	y: WHI	TE
(Specify only highe	ent's Education		(6	Give kir	int's Usual (ind of work O NOT use	done	during most	t of work	king	16	6b. Kind of B	usiness/Ir	nduatry
Elementary/Secondary (0-12)	College	(1-4or 5+)	HOME	EMA!	KER						OWN	N HOM	te.
17. Father's Neme (First, Middle	ə, Last)		1101-	Jt 44 54			18. Mothe	er's Nam	ne (First, Middl	le, M			
JAMES JOSEPH M	1cCANN						CP	THE	RINE W.	G	UDULAC	CH	
19a. Informent's Name/Reletion			19b. A	Mailing	Address (Stree			ral Route Num				in Code)
CHARLES E. GRE		/SON											MD 21042
20a. Method of Disposition	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Ob. Piace of D	Disposit	ition (Name	e of			Date		0c. Location -	-	
1 🖾 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			cemetery, WESTERN		EMETE		ce)		7/16/98		BALTIM		
21. Signature of Funeral Services	3 Licensee	5	_	STI	ERLIN	IG A		I FUN	NERAL H				228
23a. Part1. Enter the di ease, o shock, or heert failure. Lis	or complications that st only one cause on	caused the each line.	death. Do not										Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a(Chron	aic .	as	plva.	tir							lyeur
	b		to (or es a cor		Dise	a 1	•						5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due	to (or es e cor	nseque	ence of):								
Cause (Disease or Injury that Initiated events reaulting in death) Last	С	Due	to (or as a con	nseque	anca of):								
	d											1	
Part II. Other significant conditi	ions contributing to d	death but no	t resulting In th	he und	lerlying cau	use gi	ven in Part I			ld tob			to the cause of death?
									24a. Wa	as en	eutopsy ed?	a c	Were autopsy findings available prior to completion of cause
							-		10	Yes	s 2010		of death?
25. Was case referred to medica	al						26. Place	e of Dea	th (Check only	y one	,)		
examiner?	4.6					10							

Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify)

SALTU MO

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21227

8721 YI

/Medicai Examiner

Physician

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health end Mental Hygiena. Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumitic event, the Medical Examinal must be notified at once.

1 Yes 2 No

27. Manner of Death

1 Netural

2 Accident

4 Homicide

3 ☐ Suicide

29e. Certifier (Check only one)

Director

Funeral

py

To Be Completed

Physician/Medical Examiner Completed by Be Certification: To

To the Hotelful or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the bunal-transit Division of Vital Records, P.O. Box 68760.

State

31. Date filed (Month, Day, Year)

29b. Signature and title of cartifier

JUL

5 Pending

Investigation

6 Could not be determined

34LI MENSON AVE WILLIAM RUSSEL 32. Registrar'a Signature

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

28e. Piaca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. injury at Work?

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piace, end due to the ceuse(s) and manner es stated.
2 Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

30182

Registrar

Medical

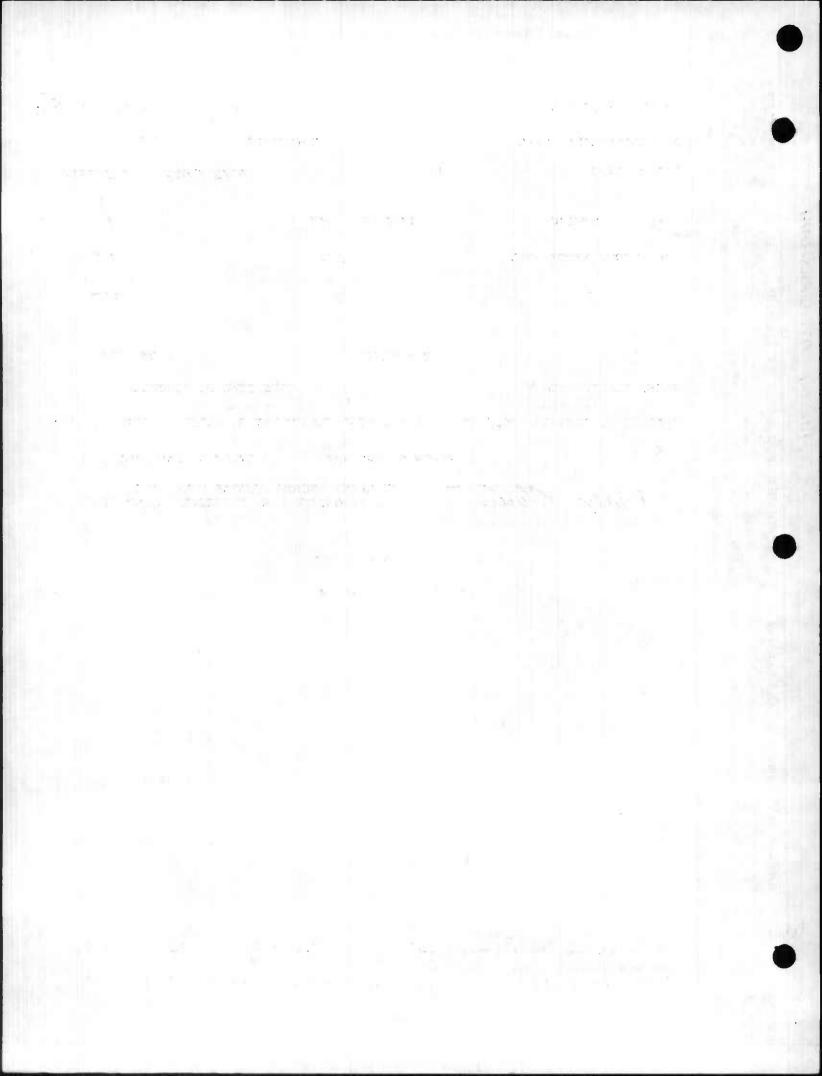
Fulla Davidson Fandare

MO

Hospital:

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

28a. Date of injury (Month, Day Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day ANNETTE GIACOMO JULY 15 1998 10:30 P.M. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) GENESIS ELDERCARE PERRING PARKWAY HILLENDALE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NEW YORK 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 👿 F Yrs. 212-24-8319 95 6/9/03 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo MD BALTIMORE PARKVILLE 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 1829 WILDWOOD AVENUE 21234 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry College (1-4or 5+) Elementary/Secondery (0-12) YEARS NURSE HOSPITAL 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) PETER GIACOMO MAMIE BUFANO 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) JANE KOEHLER NIECE 1829 WILDWOOD AVENUE BALTIMORE, MD 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Steta 20a. Mathod of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MORELAND MEMORIAL PARK 7/17/98 HILLENDALE, MD 21. Signatura of Funeral Sarvice Licansaa 22. Name and Addrass of Facility JOHNSON FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. oca, Interval Between Onsat and Deeth Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy parformed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 - Homicide 29a, Certifia to the cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier GN KA

The law requires that the death certificete be executed of Vital Records, within 24 hear To the Funeral

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

þ

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

72 hours after

e filed within 7 el Hygiena.

permit. Peges 1 end 2 should be Department of Haalth end Mentel Important: If Itam 27 is marked or

other

6 any Injury once.

Physician

/Medical Examiner

attending physicien end for use es the burial-transit

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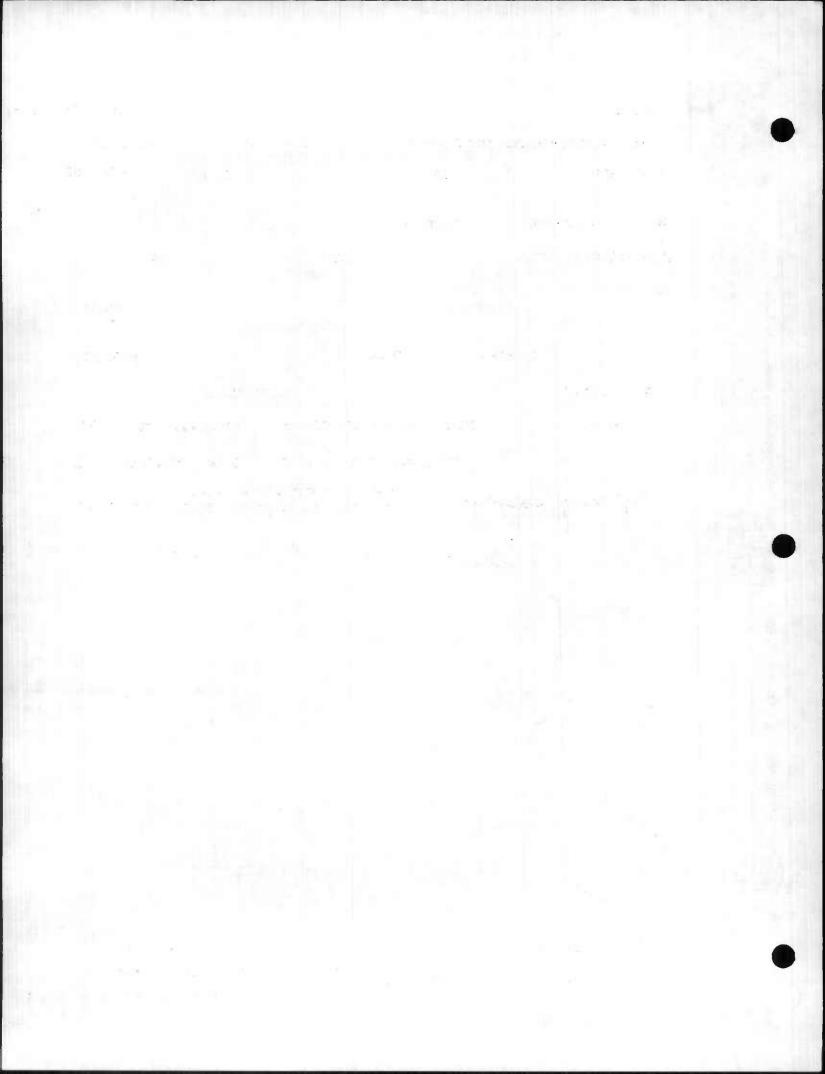
State Registrar 31. Dete filed (Month, Day, Year)

30. Name and address of parson who completed cause of death (Item 23e) (Type, Print)



198328 8903 HARTORD ROAD

BAUR. MARYCHON 2(236

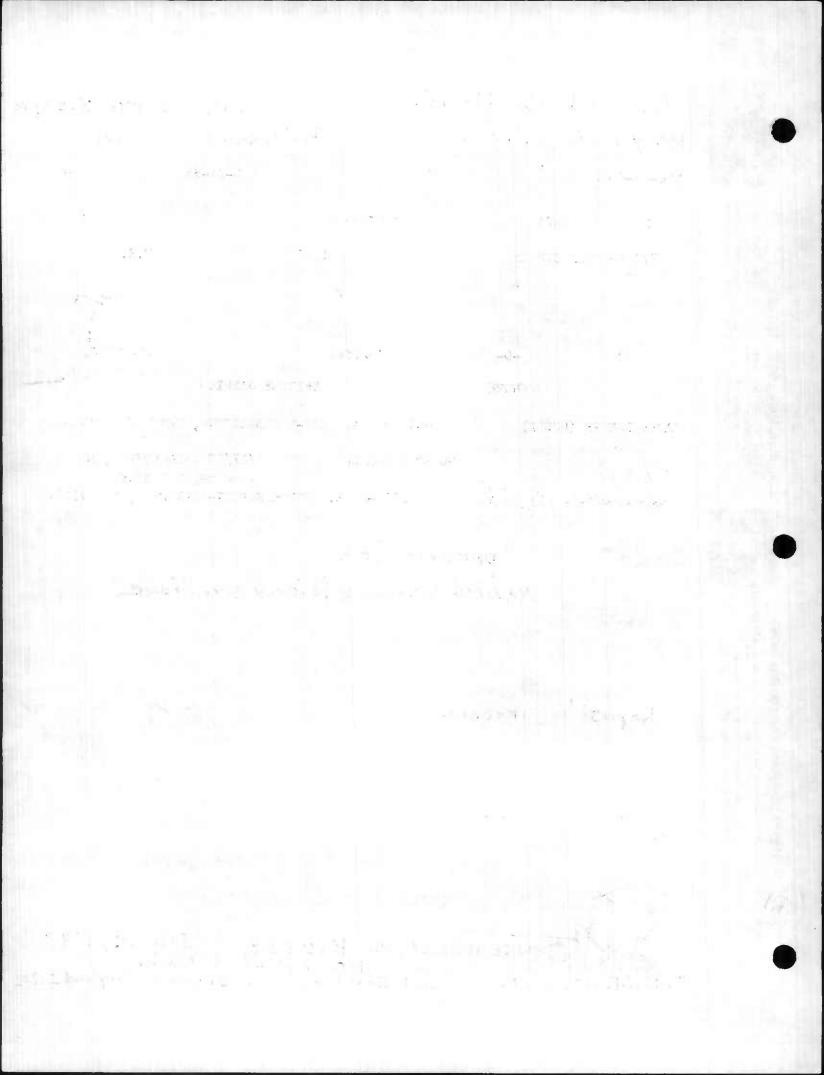


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Data of Deeth 3. Tima of Death 1. Decedant's Nema (First, Middla, Last) **Physician** Harris 3:52 pm -dward July ' /Medical 48 Facility Name (II, not institution, give street and number)
Mercy Medical Center 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Mercy N/A 5. Social Sacurify Number If Under 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Defe of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Montha Deys Hours 1 X M 2 □ F Yrs. 8-24-55 42 MD Director 220-64-8247 Usual Rasidance of Decedant the Manyland 10a. Sfata 10h County 10c. City, Town or Location 10d. Inalda City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at X□ Yas 2□ No Director BALTIMORE N/A MD 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whaf Country? U.S. 21217 722 DOLPHIN STREET Funeral 12. Was Decadant Ever in U,S. Armed Forces? 1 (X) Yas 2 □ No if Yas, Giva Yaar or Datas: 13. Was Dacedanf of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Maxican, Puerto Ricen, atc.) 14. Race - Amarican Indian. 11. Merital Status Black, Whita, efc. e filed within 72 hours after al Hygiene. other than "natural", or ite 1 □ Never Merried 2 □ Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ BLACK 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedenf's Education (Specify only highast grada completed) Elementary/Secondery (0-12) College (1-4or 5+) COMPUTER ANALYST 12 -0permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If them 27 is marked othe any injury or other traumaric avant 18. Mothar's Neme (First, Middle, Maidan Sumama) 17. Fathar'a Nama (First, Middla, Last) Be SHIRLEY HARRIS UNKNOWN 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 8841 HARKATE WAY-RANDALLSTOWN, MARYLAND 21133 JAMES HARRIS (UNCLE) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stete 20e. Mathod of Disposition 1 ☐ Buriat 2 IX Cramation 3 ☐ Ramovai from Stata 7/17/98 CATONSVILLE, MD 4 □ Donaflon 5 □ Othar (Specify) METRO CREMATORY 22. Name end Addrass of Facility 21. Signatura of Funeral Service Licensii REDD FUNERAL SERVICE 1721-27 N. MONROE STREET-BALTIMORE, MD 21217 uneure 23a. Part1. Enter the disease, or complicefions that ceused tha death. Do not antar tha mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intarvat Batween Onaat and Deeth **Physician** /Medical Immediata Ceuse (Finei disaasa or condition rasulting in daath) preumoniti Examiner ICICUC sician and burial-transit Sequentially list conditions, if any, laading to Immadiata causa. Entar Undarfying Ceuse (Diseese or Injury final Initiated avants resulting in deeth) Last physician a Box 68760 Physician/Medicai Dua to (or as a consequance of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. Division of Vital Records, P.O. 3 Probably 4 Unknown Karosis 1 □ Yee 2 No Sarcoma signed b þ 24b. Wara autopsy findings available prior to completion of cause of death? been si 24a. Was en eutopsy Completed certificate has 2 No 1 ☐ Yas 2 ☐ No 1 🗆 Yes 25. Was cesa rafarred to medical axaminar? Be 26. Placa of Daath (Chack only ona) 1 Yas 2 No Hospitei: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Appatiant 2 ER/Outpatlent 3 DOA 10 Inneral 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Mannar of Death 28c. tnjury at Work? Certification: To the Rospital of Attending P within 24 hours after death. To the Funeral Director: After Naturel 2 Accident 5 Pending invastigation 1 ☐ Yas 2 ☐ No 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyalcian: To the best of my knowledge, deeth occurred at tha tima, deta and plece, and dua to tha causa(s) and manner es stated.

| Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Cartifiar Medicai (Check only one) 29d. Date signad (Month, Day, Year) 29c. Licensa number 29b. Signatura and titla of certifiar DENICE HODGSON, MD P10228 30. Nama and address of person who complated ceusa of deeth (Itam 23a) (Type, Print) Mercy Medical Center DENICE HODGSON 301 Saint Paul Place Baltimore, Maryland 21202

State Registrar 31. Date filad (Month, Day, Year)

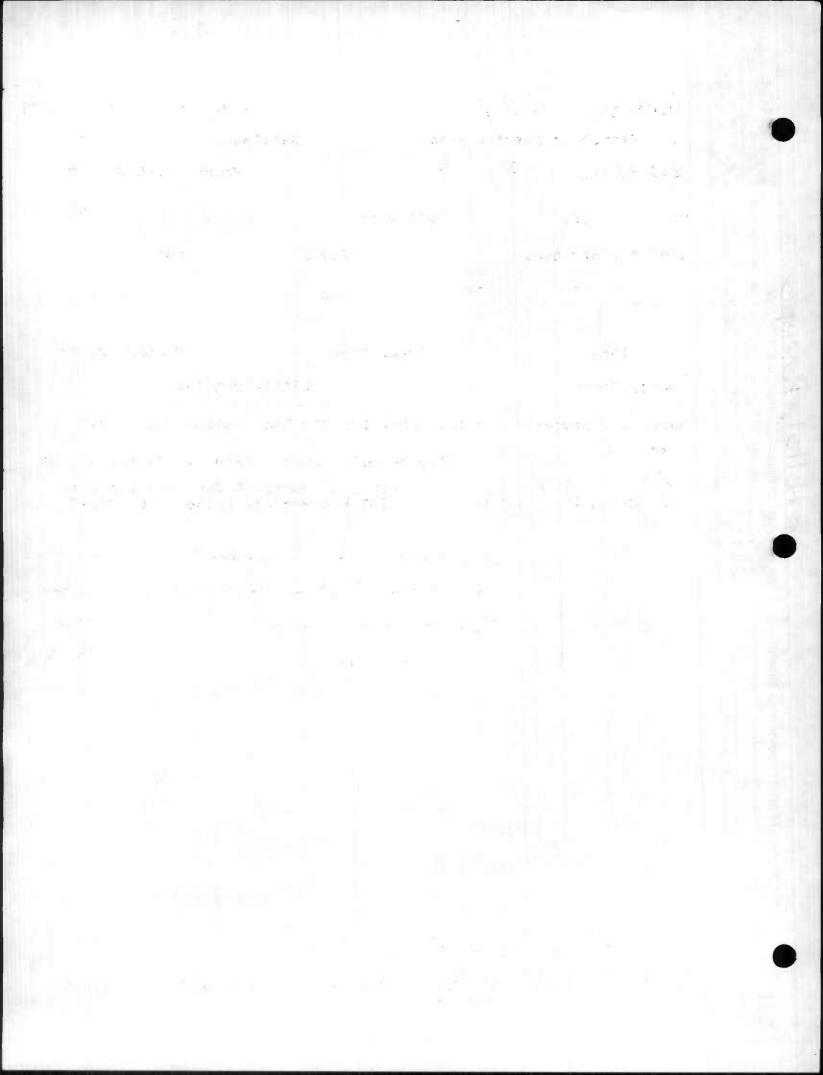
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1998 16 6,50 AT 100e /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Beeth 4c. County of Death Examiner St. Elizabeth Nursing Home Baltimore n/a Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 KF Months Days Hours 213 34 3110 Yrs March 12,1913 NC Director Usual Residence of Decedent the Meryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s4 show other traumatic event, the Modical Examinar must be notified at X Yes 2 No MD n/a Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4500 Norfolk Ave. 21216 USA 2 should be filed within 72 hours after death and Mental Hygiene. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. 1 Never Merried 2 X Barried 1 Yes 2 NX Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) 10th Seamstress Uphoistery Co. 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Henry James Lillia Colfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Hem 27 is m any injury or other treum 19a. Informant's Name/Relationship (Type, Print) 4500 Norfolk Ave. Balto., MD Laura Christopher/daughter 21217 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition ICBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/20 King Memorial Park Randallstown, MD 21. Signal yre of Funeral Sarvice Licensee 22. Name and Address of Facility James A. Morton & Sons Funeral Home 23a Part Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock or heert feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Causa (Final disease or condition resulting in death) Examiner Examiner ettending physician and lor use es the burial-transit certificate be executed Sequentially list conditions, if eny, leading to immediate causa. Entar Undarlying Cause (Disease or Injury Box 68760 Physician/Medical that initiated events resulting in death) Last 23b. Did tobacco use contributa to the cause of death? ed by the e P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by should be detact 1 Yes 2000 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Sec 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical axaminer? 26. Place of Daath (Check only ona) Hospital: Other: 4 Aursing Homa 5 Residence 6 Other (Specify) 1 Yes 2√ No 2 ER/Outpatient 3 DOA 10 1 Inpatienf this funerel 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Death Certification: of or Attending Figure 1 after death. After 1 ZNatural 5 Panding 1 Tyes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral (1 Cartifying Phyeician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifian edicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of partifier 301 unul 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) SSEILMD.3320 Benson ave. Balto, MD 21227 31. Date filed (Month, Day, Year) o Signature State when buy drop Registrar

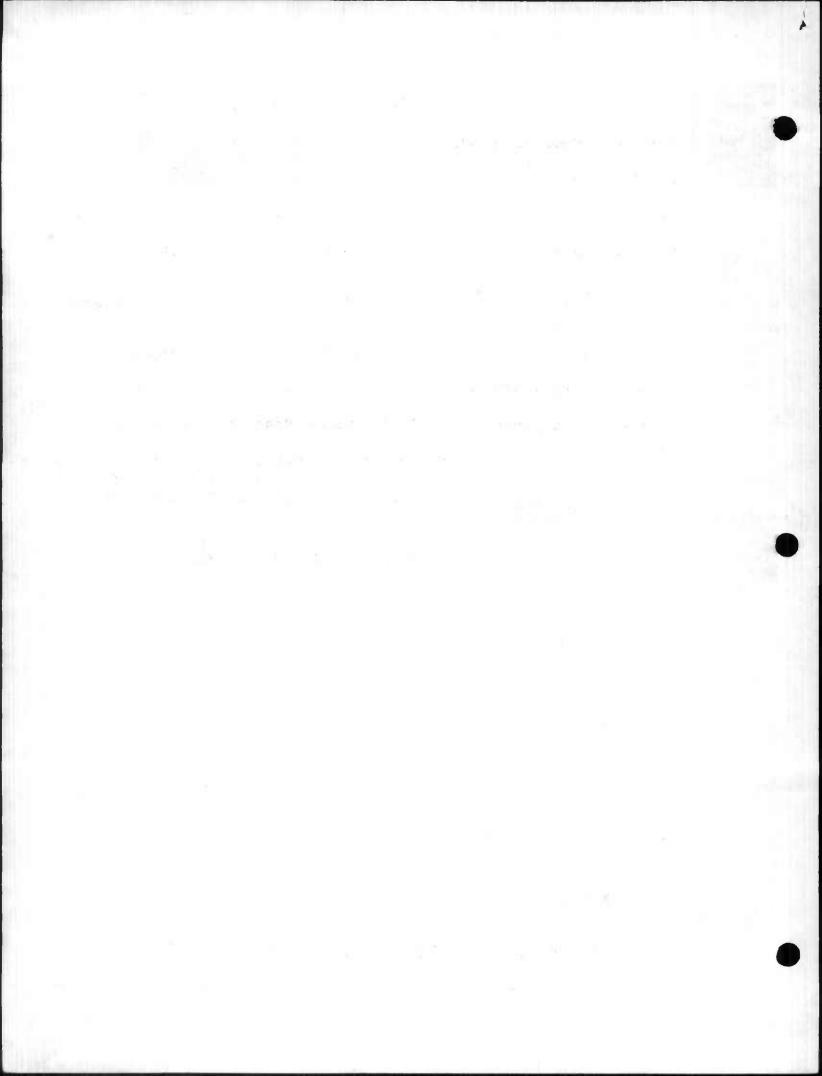


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death **Physician** Month 00 HENDERSON AHOMYA 4b. City, Town, or Location of Death 14 ULY /Medical 4a. Fecility Neme (If not Institution, give street end number) 4c. County of Deeth Examiner HOSPITAL Baltimore GOOD SAMARITAN Hours Min. 8. Date of Birth (Month, Dey, Year) 06-04-35 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer Birthplece (State or Foreign Country)
 N Y **Funeral X**□ M 2□ F Yrs. 63 **Director** 219-28-5168 Usuel Residence of Decadent 10a Stete 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23a or 28a-f ehow treumstic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Md. NA Baltimore 1 X Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1927 Swansea Road 21239 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - Amarican Indian, Black, White, etc. 72 hours efter 1 ☐ Yes 2 🛣 No If Yes, Give Yeer or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No by Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health end Mental Hyglene. Important: if item 27 is marked other than "na any injury or other treumatic event, the Medicane. Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Meat Cutter Company 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Raymond Henderson, Sr. Willie Mosley 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 1927 Swansea Road Baltimore, Maryland Henderson Gertrude 20b. Plece of Disposition (Name of cematary, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Burlel 2 □ Cremation 3 □ Removel from Steta 4 ☐ Donetion 5 ☐ Other (Specify) Kings Mem. Pk. Cem 07-20-98 Randallstown, Md Baltimore, Maryland 21202 21. Signyture of Funeral Service License 22. Nama and Addrass of Facility WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Batween Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical INFECTIOUS ENDOCARDITIS Examiner Due to (or es e consequence of): Examiner physician and s the buriel-transit thet the death certificete be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting in deeth) Lest Due to (or es e consequence of) Box 68760 by Physician/Medical Dua to (or es e consequence of) P.O. Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. ed by the a 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE Division of Vital Records, 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy DEEP VENOUS THROMBOSIS page 2 s 1 Yes 2 No 1 Yes 2 □ No ai or Attending Physician: T s after death. II Director: After this certificat ed in by the funeral director, p 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Yeer) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner stated. 29e. Certifier edicai (Check only 29b. Signature and 29d. Date signed (Month, Day, Year) 019307 and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 5601 LOCH RAVEN BLVD, BALTO. MD. FRIEDMAN 31. Dete filed 32 Registrer's Signeture State Wie Davidson Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Carrie Elizabeth Harris July 13 1998 11:15 PM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Augsburg Lutheran Home Woodlawn Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2X F Days Hours 219-28-3773 94 Vrs June 30, Director 1904 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore Maryland Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 7219 Lanark Rd. 21212 items 23a United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Maritel Stetus 2 should be filled within 72 hours efter n and Mental Hygiene. Is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: specify: White by 3 X Widowed 4 □ Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) secretary printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) George William Schneider Maria Freda Ebeling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 Department of Heelth a Important: If Item 27 is eny injury or other trac once. Barbara Harris/daughter-in-law 255 Stanmore Rd. Towson, MD 21204 20a. Method of Disposition
1 Surial 2 □ Cremetion 3 □ Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 7/16/98 Baltimore, Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. 6500 York Rd. and Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, hock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediete Ceuse (Final disease or condition resulting in death) /Medical 1 WELLC **Examiner** Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last pur Due to (or as a consequence of): Box 68760. physician Physician/Medical the Due to (or as a consequenca of) for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ₽ Onknown be det þ Records. 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s 1 Yes 2 No 1 Yes 2 To certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certificately filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 wursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 8 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and pleca, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature end title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Park Heights Avenue Battomore MD 7220 16rce Delouran

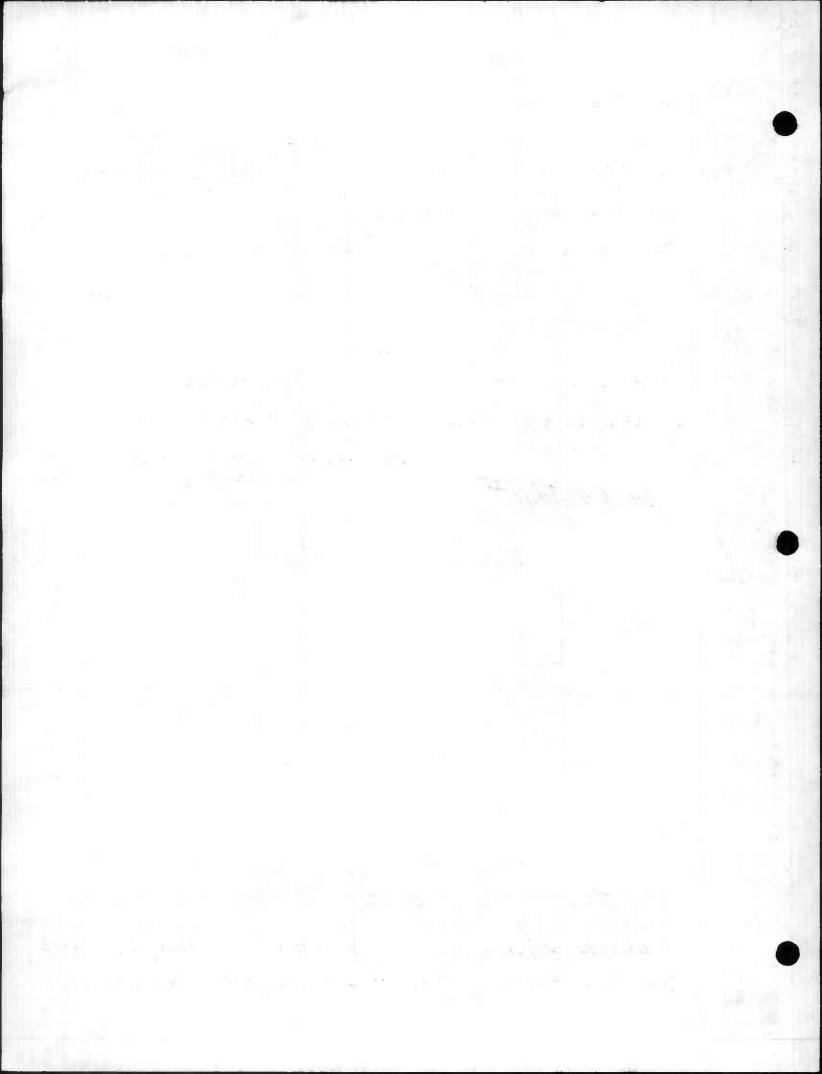
32. Registrer's Signature

who Trinder Rondon

Registrar

State

31. Date filed (Month, Dey, Year)



Hospital 24 hours To the Hosp within 24 hor To the Fune completely fi

State Registrar (Check only one)

29b. Signature and titla of certifian

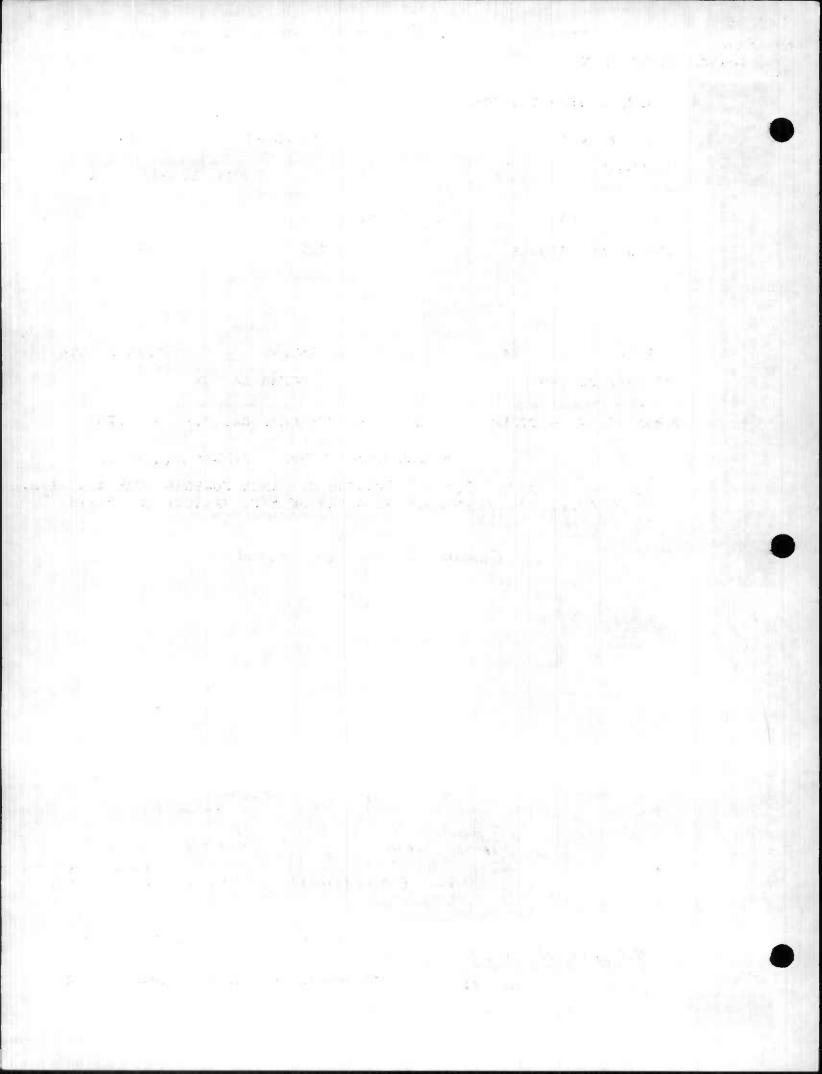
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) les Stephen S.
31. Date filed (Month, Day, Year)
JUL 171998 Radentz

29c. License number O.C.M.E

29d. Data signed (Month, Day, Year) JULY 12,1998

111 Penn Street, Baltimore, Maryland 21201

32. Hogistrary Signature Randone



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Vesi **Physician** 2:21PM JULY 15, 1998 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdey) 5. Sociel Security Number 8. Date of Birth (Month, Dey, 9. Birthplece (State or Foreign Country) **Funeral** 10 M 200 F Min. Months Deys Hours -40-Director Usuei Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or treumstic event, the Medical Examiner must be permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health end Mental Hygiene. Important: if item 27 is marked other than "naturat, or items 23s any fujury or other treumatic event, the Medical Examinator must bings. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give' Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 4. Race - American Indian 11. Merital Stetus Bleck, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) mana 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, 20b. Place of Disposition (Neme of cemetery, cremetory or other) 20e. Method of Disposition Date 18 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Dother (Specify) 21. Signature of Ednerel Service Licenses 22. Neme end Address of Fecility 8800 23a. Part. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer failure. List only one ceuse on each line. Approximete intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 1821 UATION ENTRICUIAL Examiner Due to (or es e consequence of) Physician/Medical Examiner QWKS INFAUCTION NON WAVE MUCCAUDIAL s attending physician and Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): The law requires that the deeth certificate be execu Division of Vital Records, P.O. Box 68760, CORDNAM MILEM Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 200 3 Probably 4 Unknown REUL CARLINONA Follewk þ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed SEPSU s certificate hes b director, page 2 s 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 patient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 ER/Outpatient 3 DOA this 27. Menger of Death 28d. Describe how injury occurred Certification: After 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No within 24 hours after death To the Funeral Director: , completely filled in by the 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the ceuse(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29b Signature anti-little of certifier 29c. License number 29d. Date signed (Mpnth, Day, Year) 9 D36231 M 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 6565 N. CHALLOS 21204 MD ST STE411

Registrar

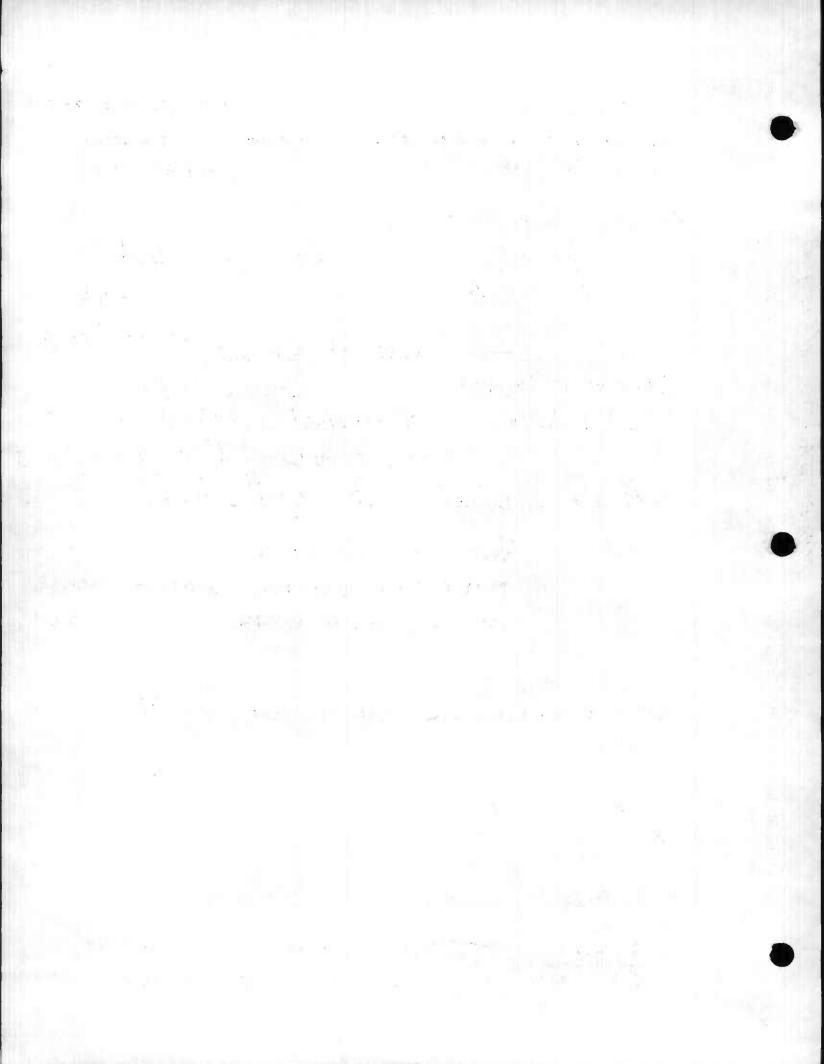
31. Dete filed (Month, Dey, Year)

JUL 17 1998

32. Registrer Signature

wha Davidson-Randall

JACOB

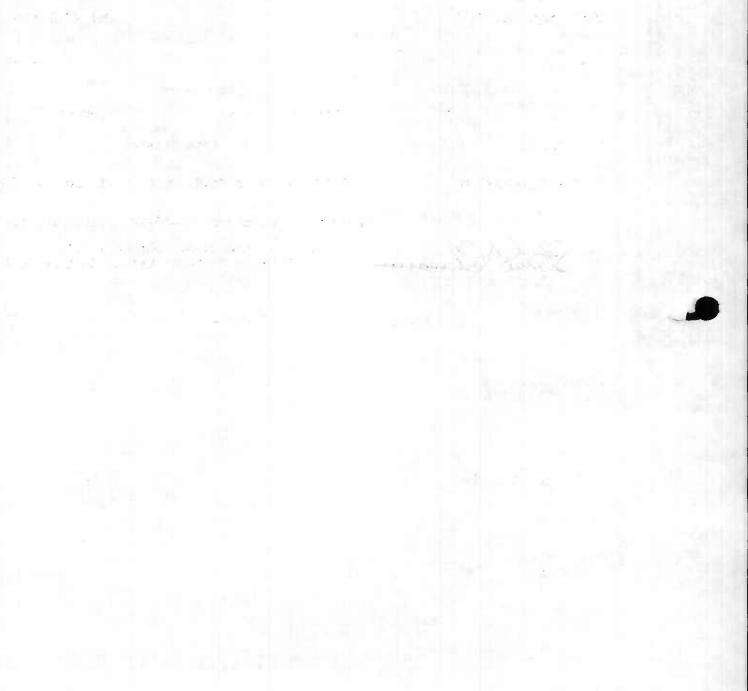


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day **Physician** Kaye Germaine 6:35PM 13 1998 July /Medical 4b. City, Town, or Location of Death 4c. County of Death Prince George 4a Fecility Neme (If not institution, give street and number) **Examiner** Bowie Larkin Chase Nursing Center 7. Age (In yrs. last birthday) If Under 1 Yeer | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Days 486 16 2349 1 M 2 SF Yrs Feb 17 1919 Director Missouri Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23s or 28s-f shov the Medical Examiner must be notified at MD Prince Georges 1 ☐ Yes 2 No Upper Marlboro Director 10a. Sireel and Number 10f. Zip Code 10g. Citizen of What Country? 1077 Largo Rd. #103 20774 United States Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23s Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Orlgin? (Specify Yes or No. If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Practical Nurse Hospital 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Fricky Anna Stranka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) permit. Pages 1 and 2 is Department of Health ar Important: If Item 27 is any Injury or other trau John Kuczynski/Son 3122 Old Largo Road, Upper Marlboro, MD 20772 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 7-16-98 Baltimore, MD 22. Name and Address of Facility CAFA - Stephen D. Lohrmann, P.A. 8717 Green Pastures Drive, Baltimore, MD 21286 ollman 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physiclan** Immediete Ceuse (Final disease or condition resulting in death) Medical PAWCREATIC CARCINOMA 98 Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest physician and s the burial-tran Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): for use as Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ached ached 1 Yae 2 No 3 Probably 4 Unknown 2 signed b by 24b. Wera autopsy findings eveilable prior to completion of cause of death? should Completed 24e. Was en eutopsy performed? has le 2 s certificate ha 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was cese referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 - Residence 8 - Other (Specify) 1 Yes 2 No 2 3D DOA this 27. Menner of Death 28d. Describe how Injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours a To the Funeral D completely filled et Cartifying Phyeician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the ceuse(s) end menner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture end litle of certifie 29c. License number D42049 eurpal Aldein completed cause of deeth (Item 23a) (Type, Print) upper Manlboro. MD. 20772 CHAMPALOUX MID Alain G.

State Registrar 31. Date filed (Month, Dey, Year)

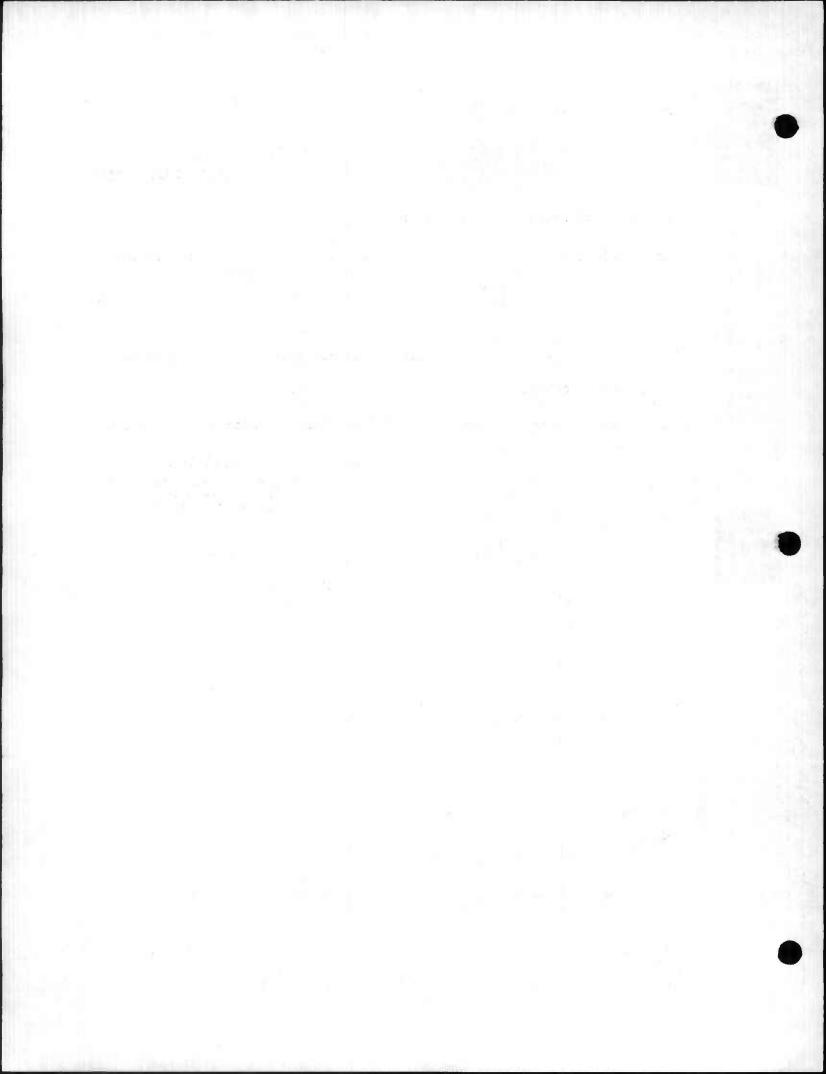
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

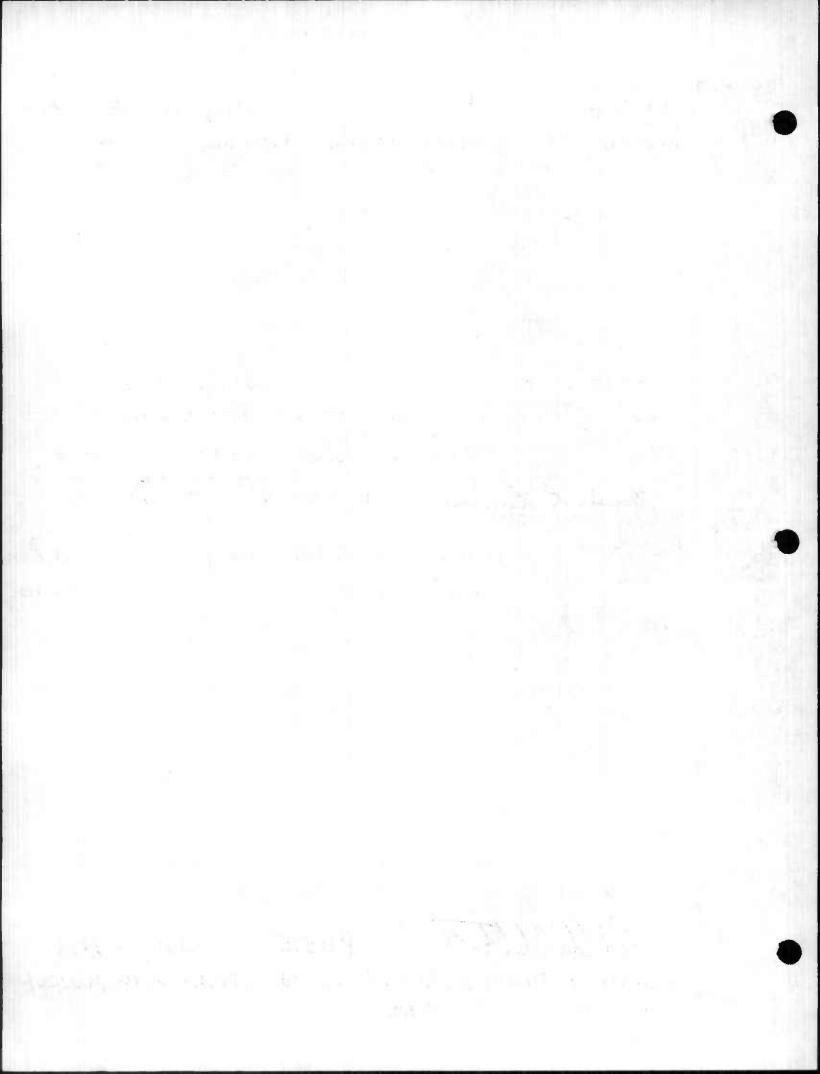
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NAME Kaiplanbat, Kuriacos



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miner		. Fecility Name (If not institution,	1 1 - 1	0	and Current	4b. City, Town, or L		4c. County	of Death	
1	5.	Social Security Number 6	Marylar 7. A	ge (In yrs. last I	ical System	If Under 24 Hrs.	8. Date of Bir	h	9 Birthold	ece (State or Foreign
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	10	be. Street and Number 2408 SARATOGA	AVENUE		10f. Zip Code 2	1227		10g. Citizen of	What Count	*
al, or items 2 Examiner mu by Funera		. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2X If Yes, Give Yeer or Dates:	7	13. Was Decedent of If Yes, specify Cub		pecify Yes or No Rican, etc.)		ce - America ck, White, e y: WHI	tc.
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To Be	17	BRADFORD D.				18. Mother's Nam	e (First, Middle, RLYN J.		.,	
-		9e. Intormant's Name/Relationship BARBARA L. KN		15	b. Meliing Address (Stree 2408 SARATO		rel Route Number			Code)
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ouce	2	I. Signature of Funeral Service Lic			22. Name and Addre	ess of Fecliity WI	TZKE FU	NERAL H	OMES,	INC.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Vaar **Physician** 13:30 John Joseph Lipton 15 JMLI 1978 /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A ff Under 24 Hrs. Hours Min. June 22, 1920 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 □ F 217-03-3942 78 Director Maryland Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show N/A Baltimore Maryland 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours efter death with and Mental Hydine.

Int: If ferm 27 is marked other than "natural; or flows 23a or inty or other traumatic event, in Mental Exercises must be a 21212 5419 Willowmere Way United States Funeral 12. Was Decadant Evar in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurateur Restaurant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Stralkas John Joseph Lipton 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Sophia M. Lipton/wife 5419 Willowmere Way Baltimore, MD 20b. Place of Disposition (Neme of cematery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Govans Cemetery 7/18/98 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. 21. Signature of Funeral Service Licensee 6500 York Rd. Baltimore, MD 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician PROSTATE Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical MCTASTASIS CANCER WITH Examiner Due to (or as a consequence of) Examiner physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Vitai Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 080 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed s certificate has b director, page 2 s 1 Yes 2 No or Attending Physician: after deeth. 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 1 Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Dascribe how injury occurred 28c. fnjury at Work? Certification: 5 Pending investigation Natural 2 No 1 Yes 2 Accident 6 Could not be determined 3 Suicida Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hou. The Funeral Div. 4 Homicide 29a. Certifier Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as steted. edica To the Hosp within 24 ho To the Fund completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the ceuse(s) and manner stated. 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifie m.A

Parking, Baltiment, MO. 21218

nd address of person who completed cause of deeth (Item 23e) (Type, Print)

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a Davidson

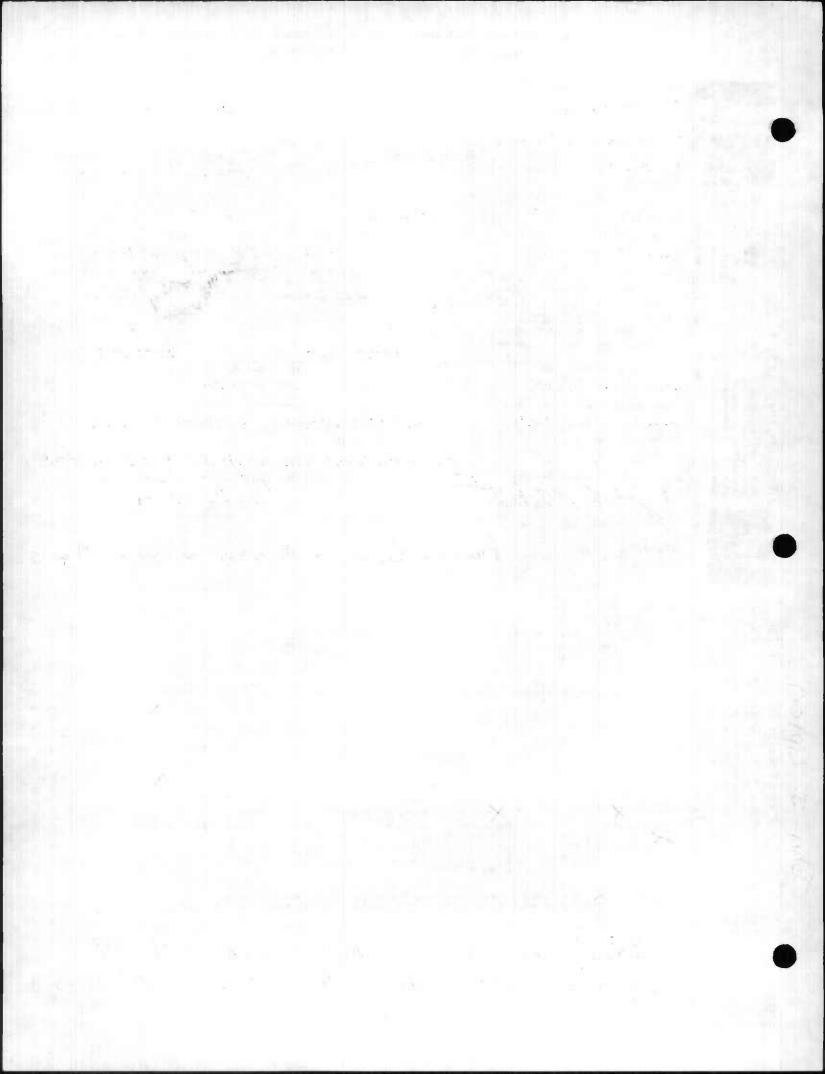
32 Registrar's Signature

University

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31. Date filed Month, Day, Year) UL, 1 7 1998

State Registrar



State of Maryland / Department of Health and Mental Hygiene 8

Certificate of Death

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3. Time of Death

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State Registrar Rebecca D. Elon, M.D.

31. Date filed (Month, Day, Year)

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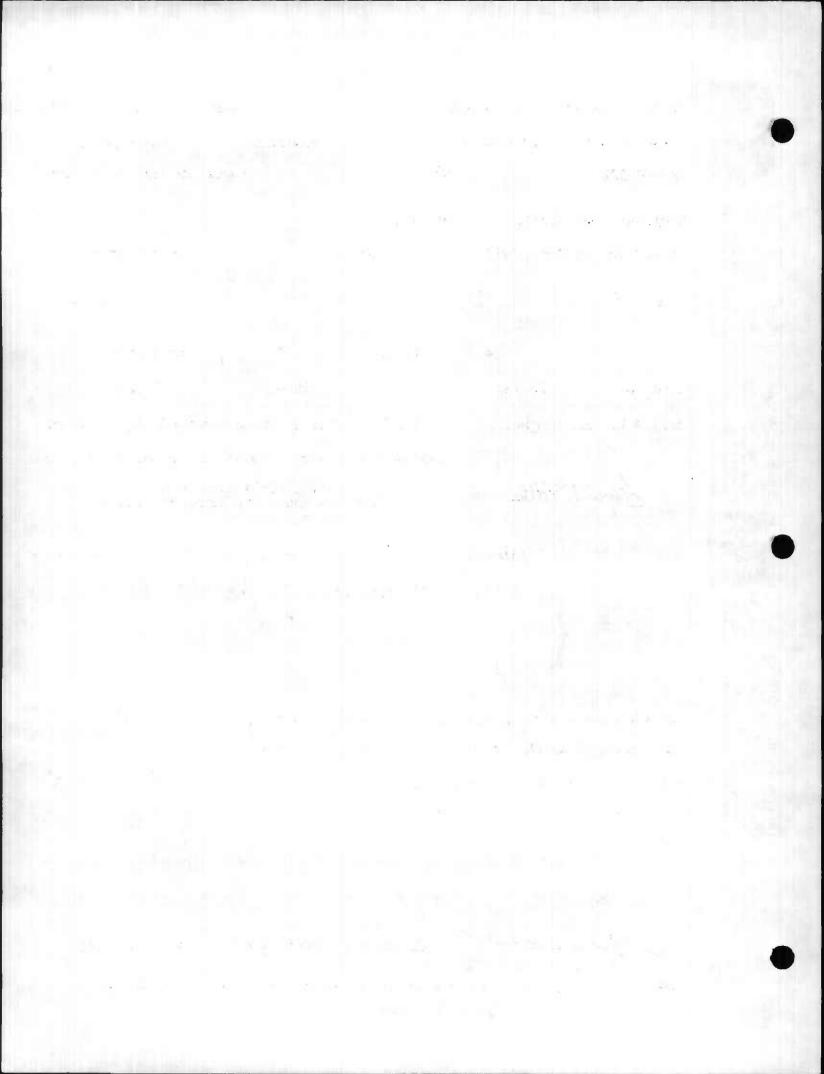
30. Name and address of parson who completed cause of death (item 23a) (Type, Print)

1454 Baltimore-Annapolis Blvd. Arnold, MD 21012
32. egistrars Signature
Findame.

29c. License number

29d. Date signed (Month, Day, Year)

July 16, 1998



Please Type or Print in Black indelible lnk, Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **ELMER** 12:25 pm JAY LARSEN 1998 JU 4a. Fecliity Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Charlestown Care Center Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Months Days Hours 16XM 2□ F 216-03-2922 MAY 29,1904 IOWA Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Co. Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane PARKVIEW 419 21228 12. Was Decadent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 Yes 2XNo If Yes, Give Year or Dates: 1 ☐ Yes ŽXNo Specify: Specify: WHITE XXWidowed 4 □ Divorcad 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Western Electric 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Ella Mattson Julius Larsen 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Phoenix, Karen E. Simon (Daughter) 21131 13717 Princess Anne Way, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Cemetery 7/18/98 Timonium, MD. 21. Signature of Funeral Servica License 22. Name and Address of Facility 4107 Wilkens Avenue NON HUBBARD Funeral Home Baltimore, MD 23a Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, and or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Fine) Months disease or condition resulting in deeth) una Cancer Due (or as a consequence of) Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest Due to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Vascular Accident 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 2 No 1 Yes 2 No 26. Plece of Death (Check only one)

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or flams 23a or any Injury or other traumatic avent, the Medical Examins man be n

21215-0020

Baltimore, Maryland

Box 68760

Records.

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To the Funeral Director: All completely filled in by the fu death.

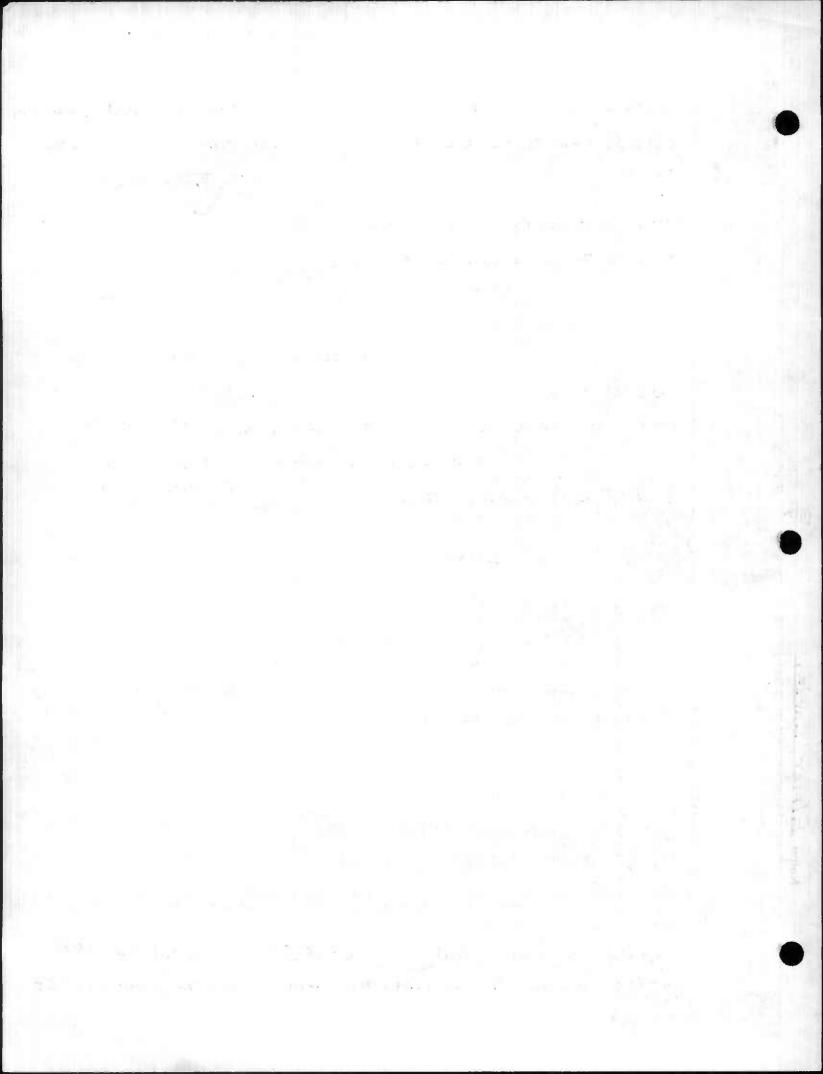
> (9 State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manger of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and manner stated. Medical 29b. Signature end title of certifier 29d. Date signed (Month, Dev. Year)

151051

711 Maiden choice Lane, Catonsville, MD, 21228 Indres Salazar 31. Date filed (Month, Dey, Year) 32 Registrar's Signature 71998 LAW CRUTCHON-V

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#23b,24a per Phy G761 7/17/98 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Deeth Belle June 22 1998 3:09 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Mariner Health of Forest Hill Forest Hill Harford 5. Social Security Number if Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Months Days Hours 212-26-9214 Yrs. June 4, 1919 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Talbot 1 ☐ Yes 2 ☑ No St. Michael's 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9802 Martingham Drive U.S.A. 21663 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ➡ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) Robert L. Embrey Belle Blair 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William V. Linn/husband 9802 Martingham Drive, St. Michael's, Maryland21050 20b. Place of Disposition (Name of cametery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State

Completed by Funeral Director

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Physician

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Pages 1 and 2 should be filed within 72 hours after death with near of Health and Mental Hygiene.

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Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

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Physician /Medical Examiner

å page 2 s Hospital or Attending Physician: n 24 hours efter death.

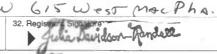
• Funeral Director: Aft
bletely filled in by the fun

4 M Donation 5 Done (Specify)	/				
21. Signature of Funeral Service Licens	Van Sant		Address of Feeling That omy Boar ore, Marylar	cd, 655 W. Baltimond 21201	ore Street
23a. Party Enter the disease, or comp shock, or heart failure. List only o	licetions that caused the death. I one cause on each line.	Do not enter the mode	of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
Immediete Cause (Finel disease or condition resulting In death)	e. Cancer	- In	in weif ,	< Type	
resulting in deality	Due to (or as	e consequence of):			
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Due to (or es	e consequence of):			
Cause (Disease or Injury that Initieted events resulting in death) Last	c. Due to (or as	a consequenca of):			
	d				
Part II. Other algnificant conditions co	ntributing to death but not resultin	g in the underlying ca	use given in Pert I.	23b. Did tobacco uae contri	bute to the cause of death? ☐ Probably 4 ☑ Unknown
				24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
				1 □ Yes 2 No	1 ☐ Yes 2 ☐ No
25. Was cese referred to medical examiner?				eath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DO	Other: 4 Nursing I	Home 5 Residenca 6 Other ((Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation			ic. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred	
3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Placa of Injury - At home building, etc. (Specify)	, farm, street, factory,	office	28f. Location (Street and Number of City or Town, State)	or Rurel Route Number,
29a. Certifier (Check only one) Cartifying Phy	rsician: To the best of my knowled Iner: On the basis of examination and menner stated.	dge, death occurred e end/or investigation,	t the time, date and place in my opinion, death occ	a, end due to the cause(s) and manne urred at the time, date and place, and	er as stated. I due to the cause(s)
29b. Signature end title of cartifier		29c.	License number	29d. Date signed (A	Month, Day, Year)
David 5	D	5	D32277	July 6,	1598

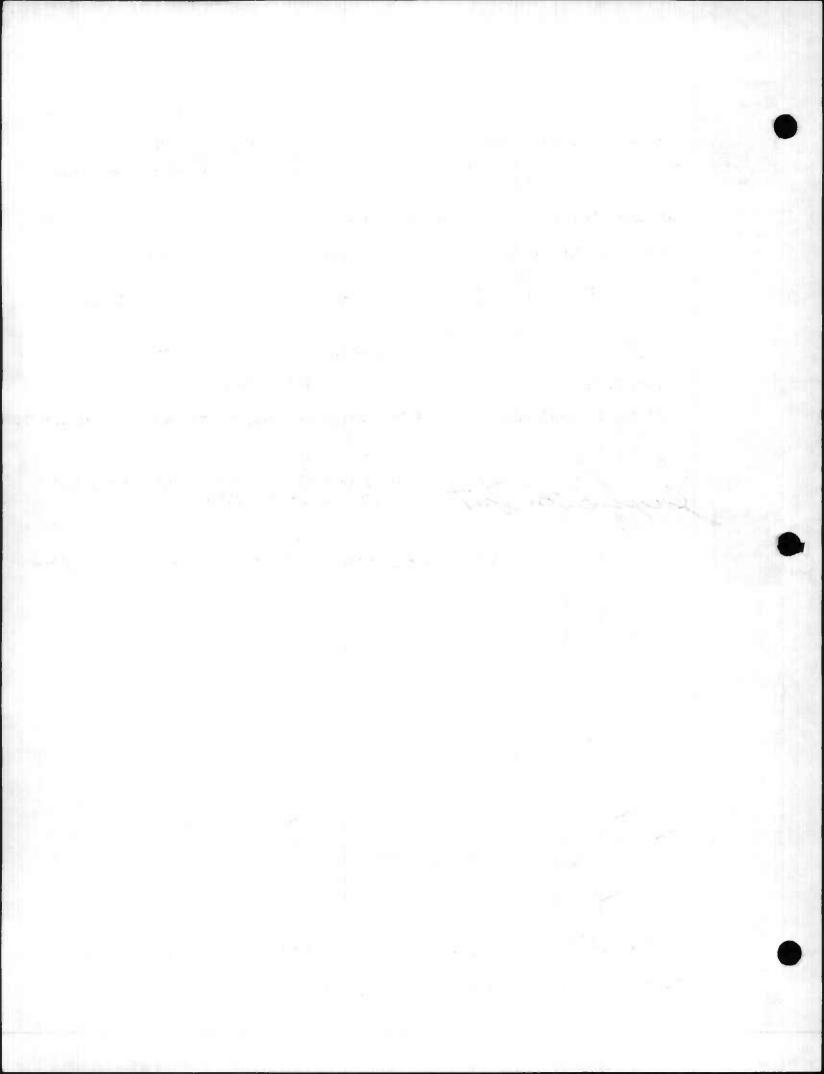
State Registrar

Chi velt 31. Dete filed (Month, Dey, Yeer)

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)



within 2 To the



State of Maryland / Department of Health and Mental Hygiene

			oraro or mar	y ica i c		cate of	Death		Reg. No.	21	980
Physician	1. Decedent's Name	(First, Middla, Last))					2. Deta of De Month			3. Time of Death
/Medical	Virg	inia An					# 63 Table 14	July.	1		9:20 AM
Examiner			nty Gen.	Чос	ni+al		4b. City, Town, or		0-		
	5. Social Security Nu		9	In yrs. last	birthday) If	Jnder 1 Yeer	If Undar 24 Hrs	8. Deta of Bir	th	9. Birthplac	a (Stata or Foreig
Funeral Director	212-50- Usuel Rasidence of B	5075	M 200 F	52	Yrs. Mo	nths Deys	Hours Min.	Sept.	20,194	.5 Mar	yland
ath with the Marylend 23e or 28e-f show wat be notified at		10b. County York	1		own or Location Rock						insida City Limits
r 28s	10e. Street and Num				10	7. Zip Coda			10g. Citizen of V	What Country	?
th wit	Grave	Run Rd.	, Box 47	0		173	27		U.	S.A.	
iffar der r ftems	11. Maritel Status 1 Nevar Marrie 3 Widowed 4	Married	12. Was Dacadant Ev Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas:			Decedent of s, specify Cut as 2 No	Hispanic Origin? (Span, Maxican, Puer Specify:	Specify Yes or No to Rican, atc.)		a - Amarican ck, Whita, ato Whit	
L L L I D-UUZU ed within 72 hours at yolene. er then "natural", or nt, pre Modical Evant	(Specif	5. Decedant's Edu				Usual Occu	pation during most of wo	rkina	16b. Kind of Bu	usinass/Indus	stry
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	17. Fether's Name (F		Hanmon	Jr.				lotte V		•	
Ve, Maryland s 1 and 2 should be file f Health and Mental Hy tism 27 is marked other other traumatic event	19a. informent's Na		Harmon,		19b Meiling Ad	Idrass (Stree	t and Number or R				ode)
2 2 3 3		W. Love					70, Gle		-		,
Caltimore, Nomit. Pages 1 and Depertment of Health moortant: If itsm 27 any injury or other trans.	20a. Mathod of Dispo	sition			e of Disposition atary, crametor			Data	20c. Location -		n, Stata Pa
Pages nant of nrt: If its iry or o		Cramation 3 □R	tamoval from Stata	Jef	ferson	cem	etery,	July 18	1998	Jeff	
Dealtimore, in permit. Pages 1 and Deportment of Health Important: if itsm 27 any injury or other to page.	21. Signature of			001			ass of Facility t Funer				
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Physician /Medical Examiner	Immediata Causa (F disaasa or condition rasulting in daath)	in al	. Metasta		Breas s a consequand		reinom	a		Зу	RS 9 mon
tricate be associted gphysician and as the burial-transit	Sequantially list con- if any, laading to im- causa. Entar Undar Causa (Disaasa or ir that initiated evants	ditions,	b	ue to (or es	a consequand	a of):					
rificate be and ng physician to as the burial	rasulting in death) Li	ist		ua to (or es	a consequenc	a of):					
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aw requ								24a. Wes	an autopsy omad?	availe	eutopsy findings abla prior to plation of cause ath?
ysician: The lav ysician: The lav is certificate hes director, page 2								10	Yas 2 No	10	res 2 No
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_ \$ 90		0	lospital:			LIDOA		Homa 5 Ras			
The stantage of	27. Mannar of Death 1 Natural 2 Accident 3 Suicide	5 Panding invastigation	28a. Data of injury (Month, Day)		b. Tima of Injury		Yes 2□No		how Injury occur		Zouta Alumbar
DIVISIO	4 ☐ Homicida	datamined	28e. Place of Injury building, atc.	y - At nome (Specify)	i, iarm, street, i	actory, office		City or To	wn, Steta)	or or moral r	toota tvoitioer,
To the Hospital within 24 hours To the Funeral completaly filler	29e. Certifier (Check only one)		sician: To the best of a ner: On the basis of a and mannar state	xamination							
Within To the comp	29b. Signatura and t	tla of certifiar				29c. Licar	nsa number		29d. Data signe	ed (Month, De	ly, Year)
	- Lisa	- Kjim,	m.P.	M. #4 C	10) (T. a D. 1 .	000	5 2479		July,	15.19	98
	200 memo	4	ompleted cause of das				THEM				
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State		1 71000	Section No	IR AMA	Handell.						

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Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: if item 27 is marked other than "naturet", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at 9068.

Be Completed by Funeral Director

10

Please Type or Print in Black Indelible Ink. Assure All Coples	Are Legit	ole.
State of Maryland / Department of Health and Mental Hy Certificate of Death		21981
Decedent's Name (First, Middle, Last) Substituting the state of Decedent's Name (First, Middle, Last)		3. Time of the th
HARRY LOUIS M'DANIEL, JR JULY	15, 19	98 4:17 M
4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deat		and the second second
GREATER BALTIMORE MEDICAL CENTER TOWSON 5 Social Security Number 6 Sex 7 And (in yrs last birthday) If Under 1 Year If Under 24 Hrs. 8 Detect Bir		TIMORE
1 M 2 F Vrs Months Days Hours Min. (Month, Days)	rth ay, Year)	Birthplace (State or Foreign Country)
219 - 26 - 1977	5-37	MD.
10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
MD BALTIMORE PARKUILLE, MO		1 □ Yes 2 No
10e. Street and Number 10f. Zip Code	10g. Citizen of W	/hat Country?
ACH AINIDU AINIDE	11	5 4
9511 EIDGELY AUEXUE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No.		- American Indian,
Armed Forces? if Yes, specify Cuban, Mexicen, Puerto Rican, etc.)	LICE	k, White, etc.
3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Yeer or Detes:	Specify:	WH UE
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Bu	siness/industry
(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)		
12 - LABOR		ofing
17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle)	, Maiden Sumam	e)
HARRY LOUIS MCDANIEL, SE DORIS L. A	MILLER	
19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number)	per, City or Town,	State, Zip Code)
20a. Method of Disposition 20b. Place of Disposition (Name of Date	E , MD.	City or Town, State
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cremetory or other place)		
4 Donation 5 Other (Specify) MORELAND MEMORIAL PRE 7/20/98		
on the man and Addition of English, C. A o	PHIEK	YILLE MD
21. Signature of Feneral Service Licensee	Funda	l Chapel
Lessa S. Wells 8800 Harters Rd. Ba	Himoe	l Chapel Nd 21234
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory a shock, or heart failure. List only one ceuse on each line.	Himoe	Chafel Hd 21234 Approximate interval Between
23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory a	Himoe	l Chapel Md 21234
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Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) end manner as steted.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) end menner stated.

29c. License number

025205

29d. Dete signed (Month, Dey, Year)

July 16, 1998

Physician /Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial and completely filled in by the funaral director, page 2 should be datached for use es the burial-tran Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate basis

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

29b. Signeture end title of certifier

JUL 171998

State Registrar

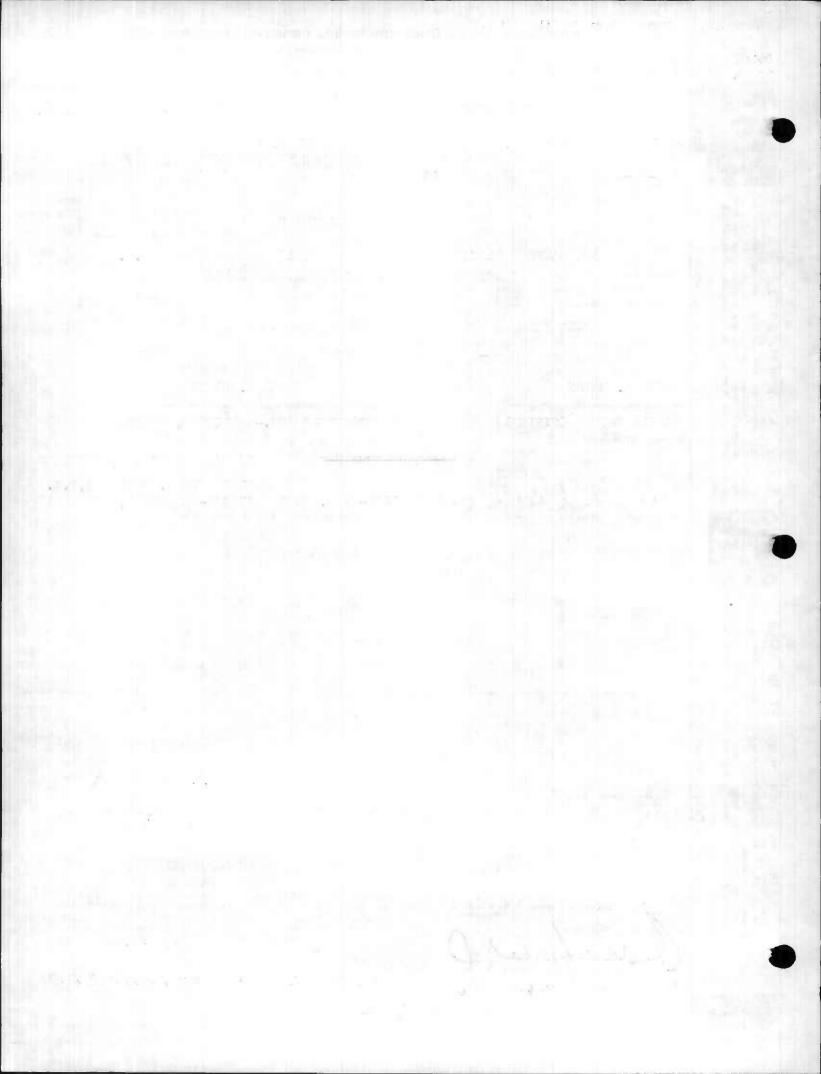
placed cause of death (Rem 23e) (Type, Print) 30. Name and address of person who com W. A. R. (ley
31. Dete filed (Month, Day, Year) N. Charles St. Bulto, and 21204 Bmc 6701

32. Registar's Simalure

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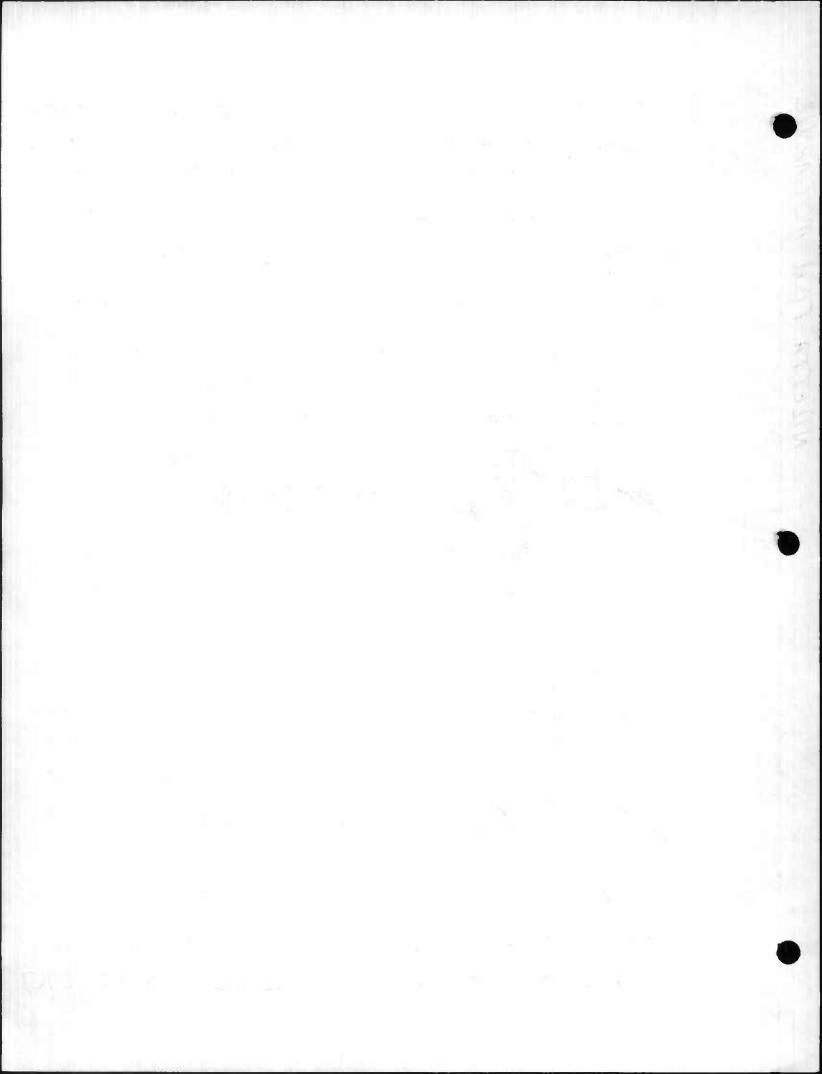
ASON ITEMS:	#23 PART I	, 27, 28A-F	PER MEO FIL	_M G76	1 '- Ceri	ificate of	Death	Re	g. No.		
Physician /Medical	1. Decedent's Nam	BRUCE B	st) KEVIN MASO	N				2. Dete of Deat Month JULY	Dey	Year	Time of Death
Examiner	4a Fecility Name (If not institution, giv	e street end number)				4b. City, Town, or Lo	ocation of Death	4c. County		
	REAR OF	504 SANFO	RD PLACE				BALTIMORE			N/A	
Funeral Director	5. Social Security N 218-58-8	210	Sex 7. Ag		lest birthdey) +5 Yrs.	Months Deys		8. Date of Birth (Month, Day, 3/18/5)		9. Birthplace Country)	(State or Foreign
72 hours after death with the Meryland natural; or frame 23a or 28a-f show older Experience must be notified at sted by Funeral Director	Usual Residence o 10a. Stete	10b. County		10c. Cit	y, Town or Loc	ation				10d.	Inside City Limits
fied a	MD		N/A			RAT.	TIMORE				1 XYes 2 □ No
or 28a-f s be notified Director	10e. Street and Nu	mber	-17.11			10f. Zip Code	TIMORE	10	0g. Citizen of V	Vhat Country?	
al D		504 SAN	NFORD PLAC	E			21217	200	U.	S.	
orner upon natural, or listing 235 or con-renow event, the Medical Examiner must be notified at Be Completed by Funeral Director	11. Maritel Status 1 XNever Marr 3 ☐ Widowed	ried 2 Merried	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Yeer or Dates:			/as Decedent of Yes, specify Cut ☐ Yes	Hispenic Origin? (Sponan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		a - American I k, White, etc.	
ed ed		15. Decedent's Ed	ducation		16a. Decede	ent's Usual Occu	pation		16b. Kind of Bu		
rt, the Medical Exp. Completed by	(Special Speci		College (1-4or	5+)	(Give k life. D	kind of work done O NOT use retire WAIT	during most of work ed) F.R	ing	HOTEL		
umatic event, III To Be Co	17. Father's Name	(First, Middle, Last,				***************************************	18. Mother's Name	e (First, Middle, M			
TOB	DAVID R.	MASON					MABEL E	E. HANDY			
- T		ame/Relationship (et end Number or Run				de)
or other traumatic	PAMELA T	HOMAS (S)	ISTER)				ELD AVEB		-		21217
ury or ou			Removal from State	₩O	Place of Dispose emetery, crem ing Memo	sition (Name of satory or other plate)	ace) Y 7	Date 7/16/98 1	20c. Location - BALTIMO		
any injury or other	23a. Part1. Enter	the disease, or com	Hector	d the deet	A 17		• MONROE String, such as cardiac		ALTIMOR	E, MD	, P.A. 21217 proximete erval Between
physician and imposite street the bunel-transit autoposite street imposite street in the street in t	Immediate Cause disease or condition resulting in deeth) Sequentially list or if any, leading to incause. Enter Undo Cause (Disease or that initiated event resulting in death)	onditions, nmediate erlying injury	aNAR(Due to (c	AND COCA	uence of):	ICATION				
ed by the attending p detached for use as detached for We as	Part II. Other signi	ficant conditions of	d	out not res	ulting In the un	derlying cause g	iven in Part I.	23b. Did to	obecco use co	ntribute to the	e cause of death?
d by Phy								1 🗆 Y	es 2 No	3 Probab	ly 4 🗆 Unknowr
2 shou								24a. Was a perform	in autopsy med?	eveile	autopsy findings ble prior to letion of cause hth?
paga 2								1/XY	es 2 No	Ar	es 2 No
rector, pag	25. Was case reference	rred to medical					26. Place of Deat	th (Check only or	10)		
this certific al director, To Be	IXXYes 2□	No	Hospital: 1 ☐ Inpati		ER/Outpatient	3LI DOA		ome 5 Reside		-	LLEY
d in by the funera	27. Manner of Deal 1 Natural 2 Accident	5 Pending Investigatio		ury ey Year)	28b. Time of tnjury UNKNOW	28c. inj W N M 1[ury at ork? □ Yes 2 ሺ No		CNOWN		
completely filled in by the funera Medical Certification:	3 ☐ Suicide 4 ☐ Homicide	6 🕅 Could not b determined	28e. Place of In building, e FOUND IN	tc. (Specif	y)	eet, factory, office	9	28f. Location (Si City or Town BALTI	treet end Numb n, State) 50 MORE MD	4 SANFOR	Oute Number, RD PLACE
pletely fill	29a. Certifier	1☐ Certifying Pt	nysicien: To the best niner: On the besis o and manner si	of examina	wledge, death tion and/or inv	occurred at the estigation, in my	time, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and ma late and place,	anner as state and due to the	ed. e cause(s)
9 E X 1	29b. Algheture end	title of certifier		0		29c. Licer	nse number	2	9d. Dete signe	d (Month, De)	y, Year)
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Comple	12 A	1 or L	DI.M	()		0.0	C.M.E.	J	ULY 12	, 1998	
within 24 hours a To the Funeral D Completely filled Medical Ce	3 Manne and add	ress of person who	completed cause of	death (Iten	n 23a) (Type, f	Print)	n Street,				21201

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death **Physician** Niletta Fish McGarvie July 12, 1998 10:43pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Daath Examiner GAR Doctors Community Hospital Prince George's Co. Lanham 5. Social Sacurity Number if Under 1 Year If Under 24 Hrs. 8. Data of Birth Mal 18, Year 12 9. Birthplaca (Stata or Foreign Country) Connecticut 6. Sax 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□M 257 86 087-09-0126 Yrs. **Director** Usual Residance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Items 23a or 28a-f shov incer must be notified at XX Yes 2 No Annapolis Director Maryland Anne Arundel 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 21401 823 Boatswain Way United States Completed by Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yas 2 M No If Yas, Give Year or Dates: NO 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Raca - American indian, Black, Whita, etc. traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married 6 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced No White 15. Dacadant's Education 16a, Decedent's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working lifa. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) Collage (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygiens Important: if Itam 27 is marked other tra-any injury or other traumatic averses 11 Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maldan Surname) Alice Maine Jesse Fish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth M. Crowley/Daughter 20b. Placa of Disposition (Name of camatery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 XX remation 3 ☐ Remova 1 m State 7/14/98 Waldorf, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Huntt Crematory 21. Signature of Funeral 22. Name and Addrass of Facility Robert E. Evans Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each interest of the complete the mode of dying, such as cardiac or respiratory arrest, Approximate Onsat and Daath **Physician** · Acute Myocardial Infarction /Medical Immediata Causa (Final hour disaasa or condition resulting in daath) **Examiner** Examiner Acute Stroke The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting In death) Last and Box 68760, Completed by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Congestive Heart Failure 24b. Wera autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 PNo certificata Division of Vital or Attending Physician: Be 25. Was case refarred to medical 26. Placa of Daath (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Investigation 1 Natural after death. 2 Accidant 1 TYes 2 No 6 Could not be datermined 3 Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicida 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medicat Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical To the Hosp within 24 ho To the Fune completaly f (Check only one) 29b. Signature and title of cartifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) Cwally 4, MD July Twelth, 1998 575 MAIO STREET, SUITE 253, LAUREL, MD 20707 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

State Registrar 31. Date filad (Mo

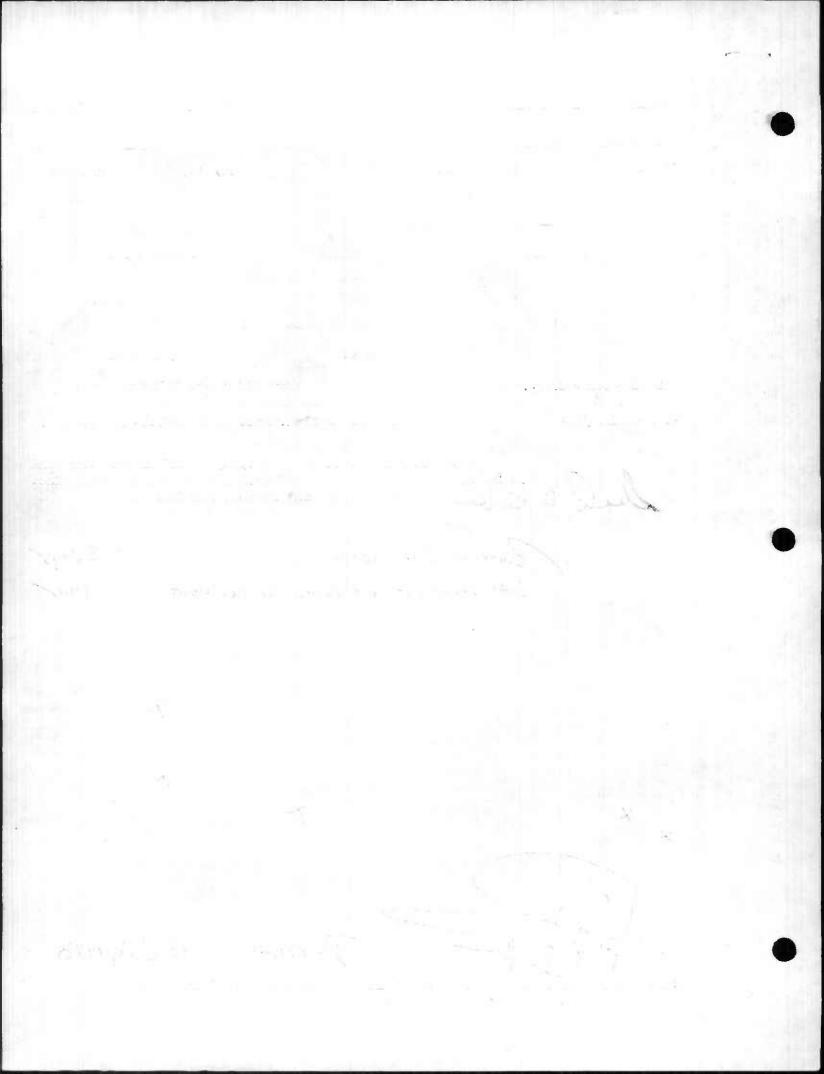


State of Maryland / Department of Health and Mental Hygiene 21984 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Louise Amelia McNeil July 12, 1998 12:26 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care - Towson Baltimore OWSON
If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) Oct. 18, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 218-68-6544 1□ M 2以F 91 Yrs. Oct. 1906 Director Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marylan show 1 ☐ Yes 2 No Director 289-MD Baltimore Towson 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? ò 509 East Joppa Road 21204 Berns 23s United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Marital Status Bleck, White, etc. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 72 hours after 1 Never Merried 2 Merried altimore, Maryland 21215-0020 8 1 ☐ Yes 2 ☐ No Specify: Specify: white à 3X Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiers. Other than Elementary/Secondary (0-12) College (1-4or 5+) 2 Homemaker Own Home 17 Father's Name (First Middle (ast) 18 Mother's Name (First Middle Meiden Surname) Be Pages 1 and 2 should be tent of Health and Mental marked William Adam Cunzeman Mary Elizabeth Unknown 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . 8800 Walther Blvd. Apt. 4601 or other tr Mr. Bob Klem/POA Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/16/98 Baltimore, Maryland Loudon Park Cemetery 21. Signature Juneral Service Licensee S. D. Coster 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Kacterial disease or condition resulting in death) neumonia Examiner Examiner offects corebrovascular accident sician and burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical the Due to (or as a consequence of): 88 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown signed t Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed The 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this certifici 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled in 115 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation in my eximple death occurred at the time data and class and discussed. edical 29e. Certifier To the Hosp within 24 hos To the Fune completely fi aminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) (Check o one) 29b. Signature a d title of ce 29c. License number 29d. Date signed (Month, Day, Year) 7041 30. Name and address of person who leted cause of death (Item 23a) (Type, Print) M.D. 1205 York Road Marc LEavey, Suite 38 Towson, Maryland 21204 31. Date flied (Month, Day, Year)
JUL 171998 Agistrasi Signature State

DHMH 16 Rev 6/95

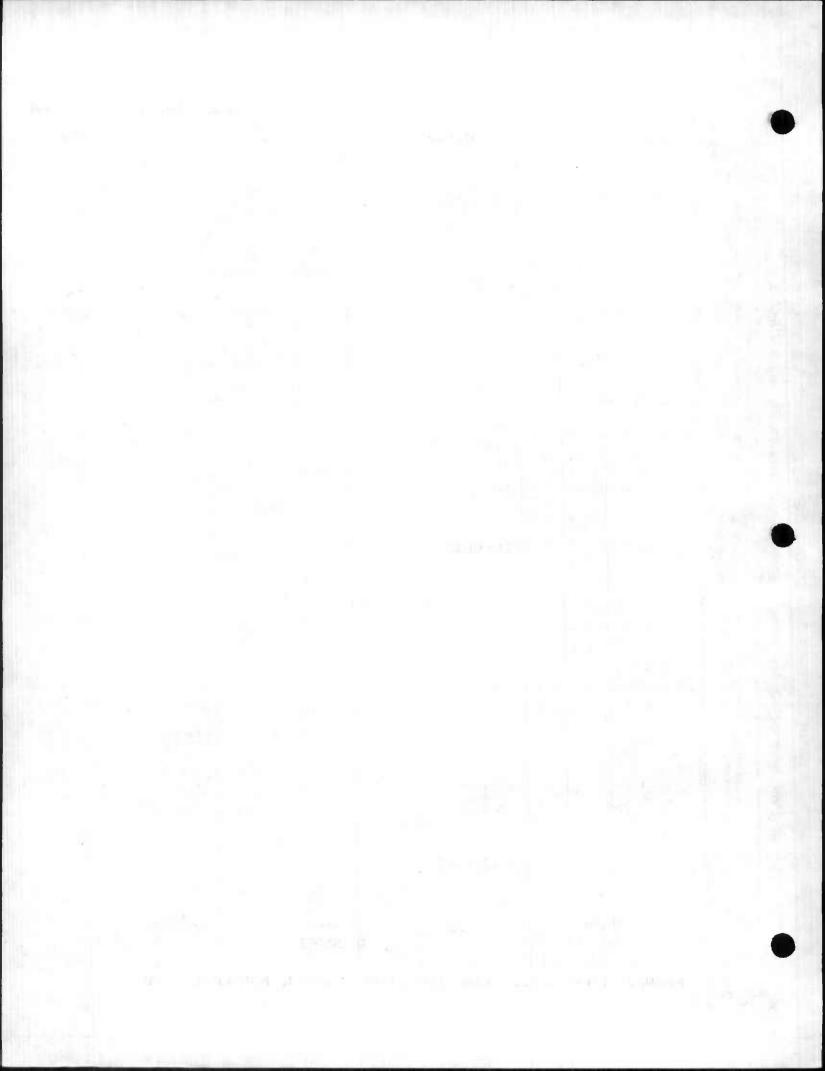
Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert Bruce Nosbaum, Sr. 14. 1998 4c. County of Death 1998 6:12 PM /Medical JULY 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) JUNE 11, 1923 9. Birthplace (State or Foreign Country)
Illinois 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days 15 M 2□ F 337-14-3496 75 Yrs. Director **Usual Residence of Decedent** 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location flied within 72 hours after death with the Menylan Hyglene. Other then "natural", or herns 28a or 28a-1 ahow ent, the deadles Exemples man the notified as 1. Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5010 Pilgrim Road 21214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X□Yes 2□No If Yes, Give Year or Dates: WWII 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, atc. 1 Never Married 2 Married Saitimore, Maryland 21215-0020 1 ☐ Yes 2 【XNo Specify: Specify: White à 34 Widowed 4 □ Divorced Completed 16a. Decedent's Uaual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) pernit. Pagas 1 and 2 should be filled wir Department of Health and Mental Hygien Important: if tem 27 is marked other the eny injury or other traumatic event, that DOGS. 12 Sales/Warehousing Beverage Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Unk. Unk. 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5010 Pilgrim Road Baltimore, Md 21214
Date 20c. Localion - City or Town, State Robert Bruce Nosbaum, Jr. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory, Inc. 7/15/98 Baltimore, MD 21. Signature of Fluencal Service-tricences Common Dawn F. McDonald. 22. Name and Address of Facility Cremation Society of Maryland, Inc. rymald 299 Frederick Road Baltimore. MD 21228 MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical PNEUMONIA Examiner Due to (or as a consequence of): attending physician and for use as the burlal-transit lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably & Unknown RENAL FAILURE bengla be ed b Records. 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy 1 ☐ Yes 2 No 1□ Yes 2 No certificata Division of Vital Physician: Be 25. Was case refarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatien1 3 DOA 1 Yes 2 No Medical Certification: To this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pin 24 hours after death.

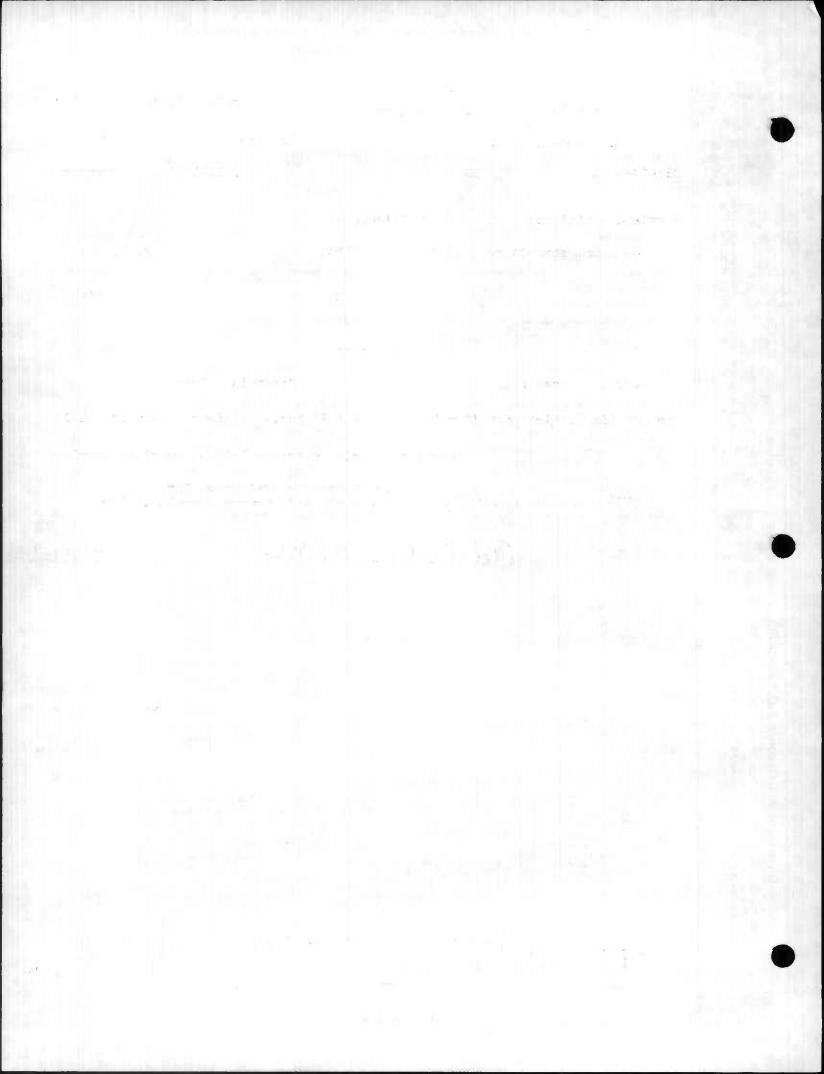
The Funeral Director: After the pletely filled in by the funeral 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, atreet, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the Hosp within 24 ho To the Fund completely f (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7-15-98 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7620 YORK ROAD, TOWSON, MARYLAND 21204 FRANCIS KHOO, M. D., 32. Registrary Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 12, 1998 Yeer July **Physician** 11:20 PM Rosalie Naunton /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) **Examiner** Baltimore Baltimore 8600 Wendell Ave. If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Year) Birthplace (Stete or Foreign Country) **Funeral** Deys Hours 1 M 2 XF Yrs. 213-20-4221 83 2-13-1915 Maryland **Director** Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Manyla 1 Yes 2 No Maryland Baltimore Directo Baltimore 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number "natural", or itsens 23s or edical Examiner must be r 21234 8501 Dempster Court, Apt C U. S. A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritel Stetus normit. Pages 1 and 2 should be tilled within 72 hours after bepertment of Health and Mental Hygiene. Important: If tern 27 is marked other than "natural", or the 1 ☐ Yes 2 🖾 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: White by 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 7 is marked other traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Mosmiller Josephine Frank George 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 8600 Wendell Ave., Baltimore, Maryland 21234 Mrs Rosalie D. Riccobono (Dtr.) 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition important: If it any injury or o 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Gardens Of Faith Cemetery 7-16-98 Overlea, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23e. Pert1. Enter the diseese, or complications that caused the shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth not enter the mode of dylng, such as cardiac or respiratory errest. Physician Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical **Examiner** Due to (or es e consequence of): Examiner The lew requires that the death certificate be executed attending physician and for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): USB BS ! signed by the a d be detached f 23b. Did tobacco use contribute to the causa of death? Pert II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? should t 24e. Wes an autopsy performed? Completed certificate has b lirector, page 2 s 2 No 1 Yes or Attending Physician: 25. Wes case referred to medicel examiner? Be 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 28d. Describe how Injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: 1 Neturel
2 Accident 5 Pending Investigation 1 Yes 2 No hours after death. Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 5 within 24 hours after To the Funeral Directory 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated.
2 Medical Examinar: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, dete and piece, end due to the cause(s) end menner stated. 29a. Certifier edicai (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cert 29c. License number noted deuse of deeth (Item 23e) (Type, Print) 30. Neme and elidress of person who co imore, Ma 600 LillemoE KEITH 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State JUL 171998 Registrar



Baltimore, Maryland 21215-0020

P.0.

Records,

Division of Vital

98-3995-033

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental H	ygiene	9
Certificate of Death		B

30. Name end address of person who completed cause of deeth (Item 26a) (Type, Print)

Radentz

31. Begister's Signature Pandall

5,

21987 RICHARD **OSBORNE** Reg. No 3. Time of Deeth 1. Decedent's Nama (First, Middla, Last). 2. Data of Death Month **Physician** Richard Wayne Osborne JULY 11, 1998 11:45A.M. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (If not institution, giva street end number) Examiner BOWIE HEALTH CENTER BOWIE PRINCE GEORGES 8. Date of Birth (Month, Day, Year) May 26, 15 If Undar 24 Hrs. If Under 1 Year 9. Birthplece (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Min. 1XX 2 F 227-60-8760 Yrs. 51 **Director** Usuel Residence of Dacedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 X Yes 2 □ No Maryland Directo Prince George's Bowie 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? b the Medical Examiner must be 20715 United States 2610 Kimble Lane or items 23s Funeral 12. Was Decedant Evar in U.S. Armed Forcas? 1 XIXes 2 □ No if Yes, Give Year or Datas: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, etc. 11. Meritel Status 1 Never Married 2X Married Specify: White 1 ☐ Yes 2 XXo Specify: ğ 3 Widowed 4 Divorced 'natural'. Completed 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) County Police Officer County Government 4 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mantal should be marked William Osborne Susie Gregory 2 in m 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If them 27 is 2610 Kimble Lane Bowie, MD 20715 Gay Ellen Osborne/ Wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Steta 20e. Method of Disposition 7/15/98 1 Deurial 2 ☐ Cremetion 3 ☐ Removel from Steta 4 ☐ Donetion 5 ☐ Other (Specify) ò Crownsville, MD Maryland Veteran's Cemetery 22. Nama and Address of Fecility 21. Signature of Funeral Servica Licensee Robert E. Evans Funeral Home, Inc anusk 16000 Annapolis Road Bowie, MD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death only one cause on each line **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical e. Atheroscleratic Cardiovasiular discase Examiner Due to (or es a consequence of): Cardiomyopathy Examiner dilated physician and s the bunal-trans Sequantielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequenca of): certificate be execu Physician/Medical Due to (or es e consequenca of) 98 950 23b. Did tobacco uea contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown signed by þ 8 24b. Were autopsy findings aveileble prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? page 2 certificate has 1 Yes 2 □ No 1 Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Yes 2□ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) unerai 28d. Describe how injury occurred 27 Menner of Death 28b. Time of Certification: 28c. Injury at Work? After 5 Pending Investigation or Attending 1 Netural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, and due to the cause(s) and menner as stated. edical 2 XMedical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29d. Data signed (Month, Day, Year) 29b. Signeture end title of cartifier 29c. Licansa number

O.C.M.E.

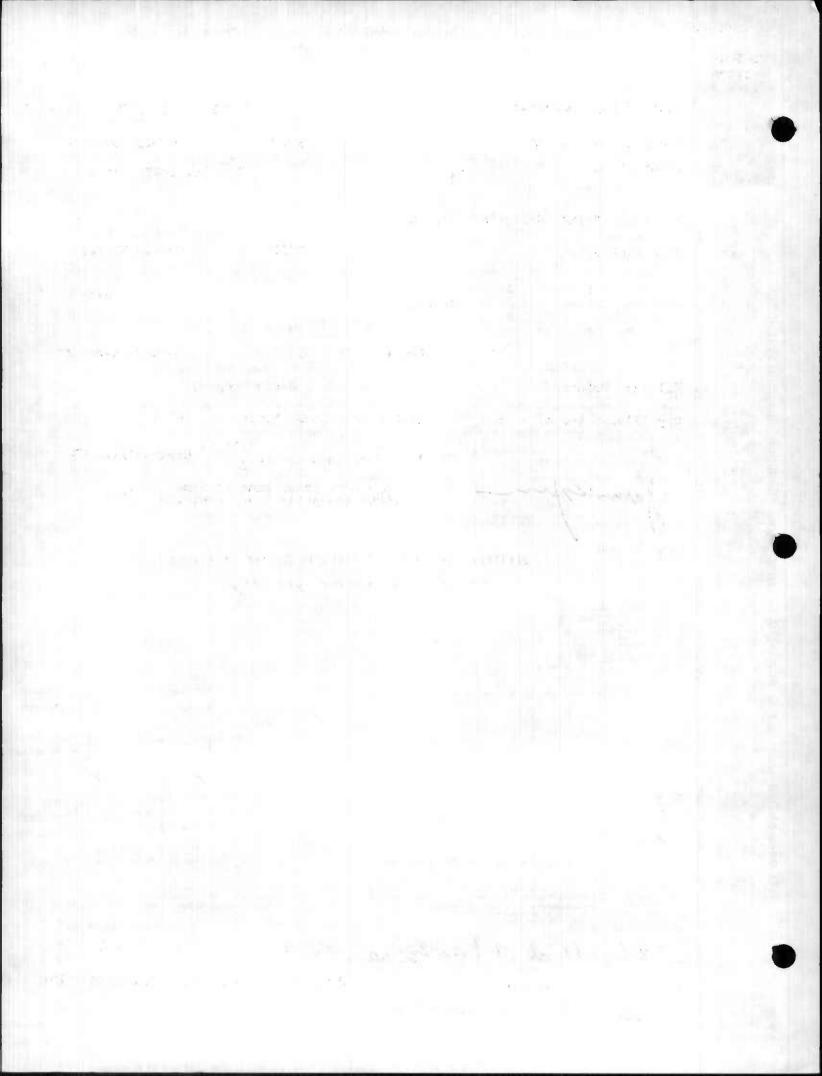
JULY 12,1998

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Stephen

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 21988

				Certificate	of Dea	ith	F	leg. No.) (1900	
hysician	1. Decedent's Nama (First, Middle, L	ast)					2. Dete of Dea Month	th Day	Year	3. Tima of Death	
dical	EVA LOT	JISE		PRIC	E		JULY			10:15 P	M
er	4a Facility Nama (If not institution, gi Saint Joseph	Medical C	enter			Towso				imore	
	5. Social Security Number 214-34-3561 Usual Rasidence of Decedent	Sex 1 □ M 2 X F	(In yrs. last bin	thday) If Under 1 Months Yrs.	Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day February	23,1910	9. Birthpl Count Maryl	laca (Stete or Foreig try) Land	ın
or	10a. State 10b. County Maryland Carroll		10c. City, Town	or Location ostead		0			10	0d. Inside City Limit	
rect	10e. Street and Number		-	10f. Zip (Code			10g. Citizen of	What Coun	itry?	_
ai O	2320 North Cape Ho	orn Rd.			21074			United	Stat	es	
by Funeral Director	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yas 2 No If Yes, Give Year or Detes:		13. Was Decede If Yes, specif			ecify Yes or No- Rican, etc.)	14. Red Ble Specif	ce - Americ ck, White, o by: Whi	etc.	
eted	15. Decedent's E (Specify only highest g		16a.	Decedent's Usuel	Occupation done during	most of work	ina	16b. Kind of 8	usiness/Inc	Justry	
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To Be	Foster Bowdle Day	ris			(Carrie	Noble I	Long			
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	20a. Method of Disposition	/11		812 Cotta		ie s	tevensor	20c. Location	21286 - City or To		-
	1 Burial 2 ☐ Cremation 3			Disposition (Name y, cremetory or oth		. !-					
	4 □ Donetion 5 □ Other (Spec 21. Signature of Funerel Service Lice		Morela	nd Memor	1al Pa	rk /	/20/98 chell-Wi	Baltimo	ore, M	laryland	
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1 r	Immediate Cause (Final disease or condition resulting in death)	ACUTE M	YUCARI	DIAL IN	FARCT	ION				HOURS	
al le		ACUTE C		consequence of): TIVE HE	ART F	AILUR	E		l t I	Hours	
edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or injury that injuried executed)	. RESPIRA	TORY (SECON	DARY	то			HOURS	
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Be	25. Wes case referred to medical axaminer?	Hospitel:				Place of Dee	th (Check only o	ne)			
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edicai	29a. Certifier 1 Certifying P (Check only one) 1 Certifying P	hysician: To the best of a miner: On the basis of a and manner state	xamination and	, deeth occurred e d/or Invastigation, i	t the time, dat in my opinion,	e end place, deeth occur	end due to the or red at the fime, or	euse(s) end m date end place,	enner as st , and due to	tated. the cause(s)	
M	29b. Signature and time of contilier	00	5		License num	ber		29d. Dete signe	ed (Month,	Day, Year)	
	30. Neme and address of person who	completed cause of dea	th (Item 22a)		5886			July	. 17	. 199	8
	LILIA CEBALLOS	, M.D., 7	620 YO	ORK ROAL	D, TO	YSON,	MARYL	AND 21	204		
State istrar	31. Date filed (Month, Day, Year) JUL 17 1998	32 Registrar	s Signature	nda B2.							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JULY **Physician** 11, 1998 11:11 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** BALTIMORE TOWSON MEDICAL CENTER GREATER BALTIMORE 9. Birthplace (State or Foreign If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 6. Sex **Funeral** Months 18-3812 100 M 20 F Deys NORTH Director Wec 160 Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan neart of Heelih and Mentil Hygiane. ant. If them 22 is marked other than "natural", or itams 23a or 28a-f show not or other traumatic event, the Modest Exercises must be notified as 1 ☐ Yes 2 No Directo IMBNIUM Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2109 Funeral 12 Wes Decadent Ever in U.S. Was Decedent of Hispenic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 20 No Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired). (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) COYPS 18. Mother's Name (First, Middle, Meiden Sumeme)-17. Father's Neme (First, Middle, Last) Be 19b. Meiling Address (Street end Number or Rura) Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is any Injury or other train once. OCKEUSVILLE 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) July 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State Valley Mem. Garder 4 Donetion 5 Dother (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland 2109 Approximete Intarval Between Onset end Death **Physician** enscleritic heart distuse /Medical tmmediate Cause (Finel disease or condition resulting in death) **Examiner** Physician/Medical Examiner physican and as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of): ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Qunknown 1 ☐ Yee 2 ☐ No Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy peen : page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata or Attending Physician: funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1□ Yes 2Z No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27, Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) After Netural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu death. 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1SCertifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es atated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier

death (Item 23a) (Type, Print)

32. Registrat & Signature

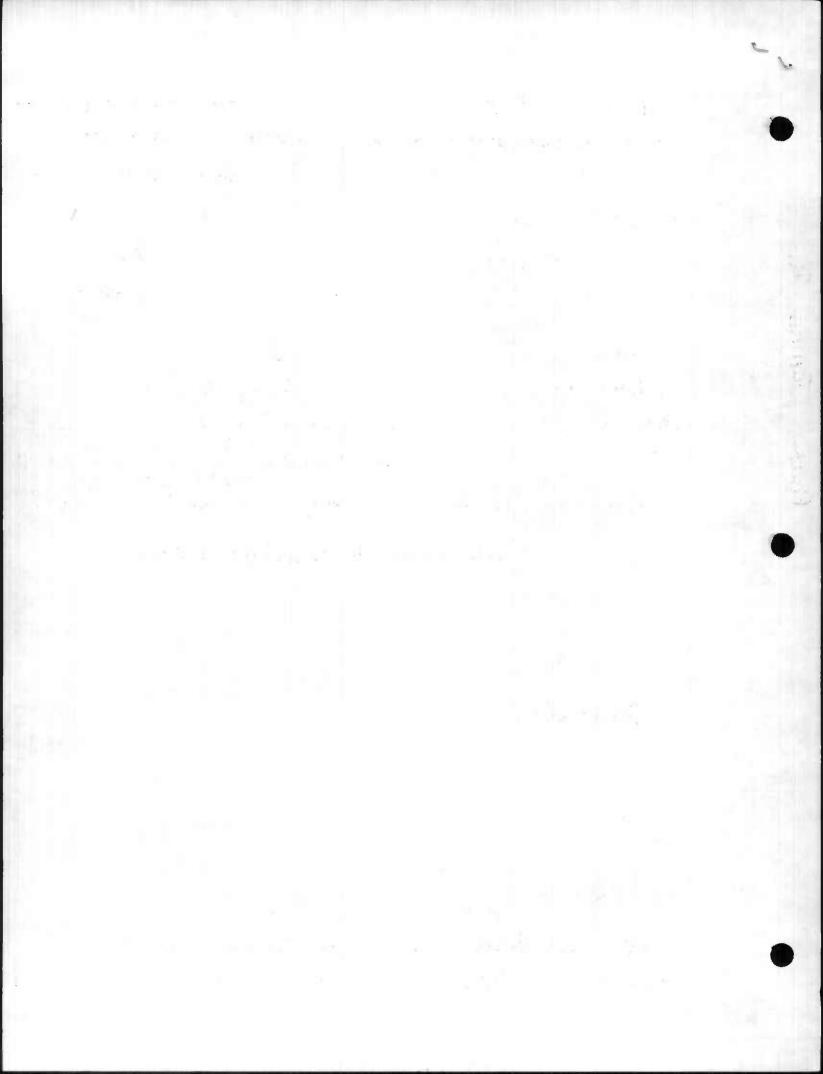
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CHARLUT ST BATTIMORE

State Registrar 30. Neme and eddress of person who completed d

31. Date filed (Month, Day, Year) JUL 17 1998

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **JOHN** Certificate of Death Reg. No. PANGLE JR 2. Dete of Death 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) Month **Physician** John Earl Pangle, Jr. JULY 13, 1998 5:10P.M. /Medical 4a Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1330 SARGEANT STREET BALTIMORE If Under 1 Year If Under 24 Hrs. Birthpieca (Stete or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. lest birthdey) 8. Deta of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Deys Hours Min. Yrs. **Director** 215-60-2133 45 FEB 25,1953 Maryland Usual Rasidence of Dacedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MD N/ABaltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1330 Sargeant Street 21223 USA 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. Pm 27 Is marked other than "natural", or items 23. Funeral 12. Was Decedant Ever in U,S. Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indian. Bleck, White, etc. 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas: 1 Never Merriad 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White Àq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 Collega (1-4or 5+) Truck Driver Trucking traumatic event, 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) John Earl Pangle, Sr. Theresa Elizabeth Newell 19a. informent's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai page. Tina Marie Thomas/Sister 2697 Dulany St. Baltimore, MD 21223 Placa of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory 7/16/98 Baltimore, MD 21. Signatura of Fund Dawn F. McDonald

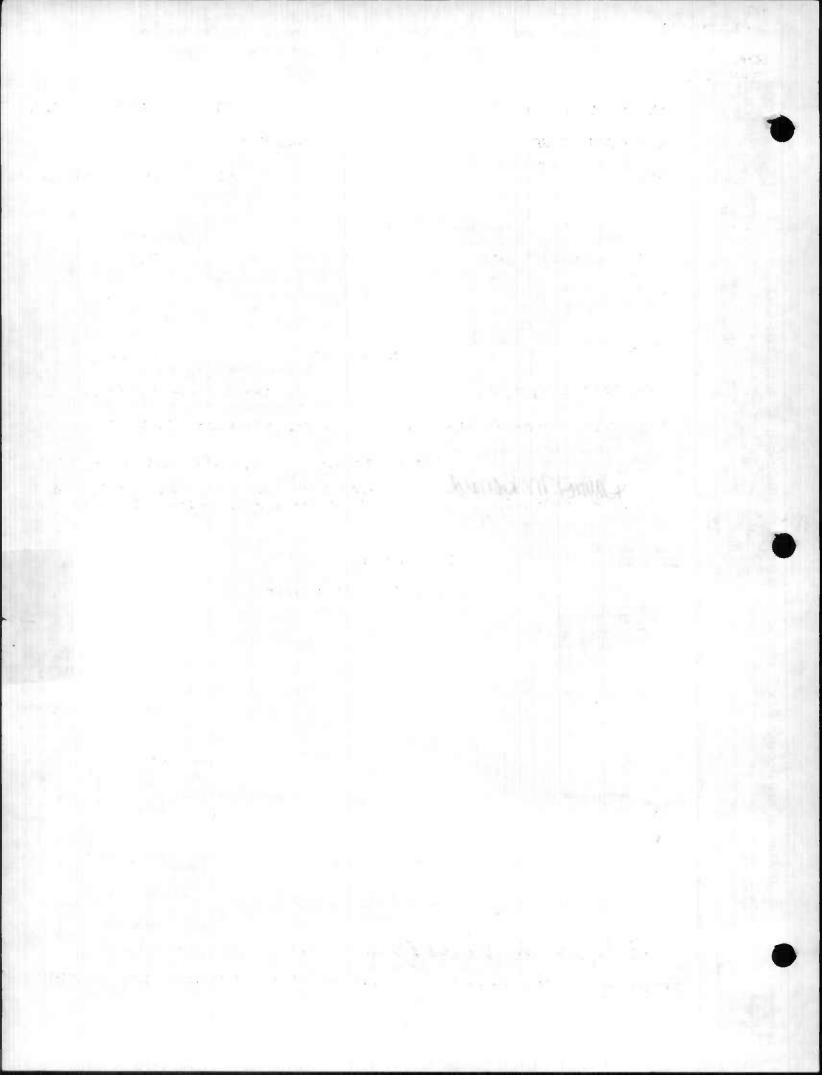
299 Frederick Rd Balto, MD 21228

23a. Pentl. Enter the disease, or complications that causad tha daath. Do not anlar tha moda of dying, such as cardiac or raspiratory arrast,

Approx 22. Nama and Addrass of Facility Approximata Intarvel Between Onsat and Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical CICCHOSI Examiner Dua to (or as a consaquance of): Examiner alcoholism Mronic ettending physician and for use es the burial-transit certificate be executed Sequentially list conditions, if eny, laading to immadiata causa. Enter Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Box 68760 Physician/Medicai Dua to (or as a consaquance of): 23b. Did tobacco use contributa to the causa of death? Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. P.O. the signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown g Records, 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? peen complation of causa of death? Limited has 12 Yas 2 No 1 Yas 2 No of Vital 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Deeth (Check only one) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Lo 1 No 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28d. Dascribe how Injury occurred 27. Mannar of Death 28a. Data of injury (Month, Day Year) 28b. Tima of 28c. injury at Work? After t Certification: or Attending F after death. Director: After Division 1 Natural 2 Accident 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 6 Could not be dataminad 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) à 4 T Homicida filled In 24 hours a Funeral D 29a. Cartifian 1 Cartifying Physician: To tha bast of my knowledga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one) To the Vithin 2 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifiar JULY 14,1998 O.C.M.E. 30. Nama and addrass of person who complated causa of daath (Itam 23 at Type, Print) Radentz 111 Penn Street, Baltimore, Maryland 21201 hen

3. Registratification

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#4bper Phy, #5,7 per FH G761 7/17/98 EW 1. Decedent'a Nema (First, Middla, Last) 2. Data of Death Month Year OSSANO June 30, 1998 12:35 PM 4a. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Ballo 21218 Ballo home Balto. 6 reenway 5601 If Undar 1 Yeer | If Under 24 Hrs. 5. Social Security Number 00206. Sax 7. Age (In yrs. lest birthday) Birthplace (Stata or Foraign Country) Days Hours 1X M 20 F 216 07 002 93 Maryland Usuel Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits Maryland Baltimore City 1 Yas 2 □ No Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3601 Greenway 21218 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 14. Race - Amarican Indian, Bieck, Whita, atc. 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11, Maritai Status 1 Never Merried 2 Married 1 ☐ Yes 2 🕱 No if Yas, Giva Yaar or Datas: 1□ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Coilega (1-4or 5+) 12 Publisher Publishing House 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maiden Surnama) Edward Boetler Passano Eleanor Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary Passano/wife 3601 Greenway, Baltimore, Maryland 21218 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovel from Stata 4 Donation 5 □ Othar (Specify) 22. Name end Addrass of Facility State Anatomy Board, 655 W. Baltimore Street 21. Signeture of Funeral Service Licensee Joseph B. Sant Baltimore, Maryland 21201 3a. Part Lantar tha diseasa, or complications that cadsed the shock or haart tailura. List only ona cause on aech lina ed tha daath. Do not antar tha moda of dying, such as cardiec or respiratory arreat, Immediate Cause (Final disaasa or condition rasulting in death)

Physician /Medical Examiner

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Examiner

Physician/Medical

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Certification: To

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Physician

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Examiner

10a. Stata

Funeral

Director

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Director

Funeral

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death

permit. Pages 1 and 2 should be filed within 72 hours after begannent of Heelth and Mental Hygiene. Interportant: If item 27 is merked other than "naturel", or having or other traumette.

Baltimore, Maryland 21215-0020

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaase or injury thet initiated avants rasulting in daeth) Lest

29b. Signatura and titla of certifier

	d	
Part II. Other signiffcant conditions of	contributing to death but not rasulting In tha undarlying causa givan In Par	1 Yes 2 No 3 Probably 4 Unknown
		24e. Was an eutopsy performed? 24b. Ware autopsy findings available prior to completion of cause of death? 1 Yas 2 No
25. Was casa ratarred to medical	28. Pla	ace of Death (Check only one)
examiner?	Hoapital: 1 Inpatlant 2 ER/Outpatient 3 DOA Other: 4 I	Nursing Homa 5 Rasidenca 6 □Othar (Specify)
27. Manner of Death 1 Natural 5 Panding 2 Accidant invastigation	28a. Deta of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work?	28d. Dascribe how injury occurred ☐ No
3 Suicide 8 Could not b 4 Homicida datarminad		28f. Location (Street and Number or Rural Route Number, City or Town, Stata)
	nyalclen: To the best of my knowledge, death occurred at the time, date a miner: On the bests of axamination and/or invastigation, in my opinion, dean menner stated.	

certificate be executed Division of Vital Records, P.O. Box 68760, 980 signed by t or Attend after deeth Director: / To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th

30. Nama and addrass of person who complated causa of (6ath (Item 23a) (Type, Print)

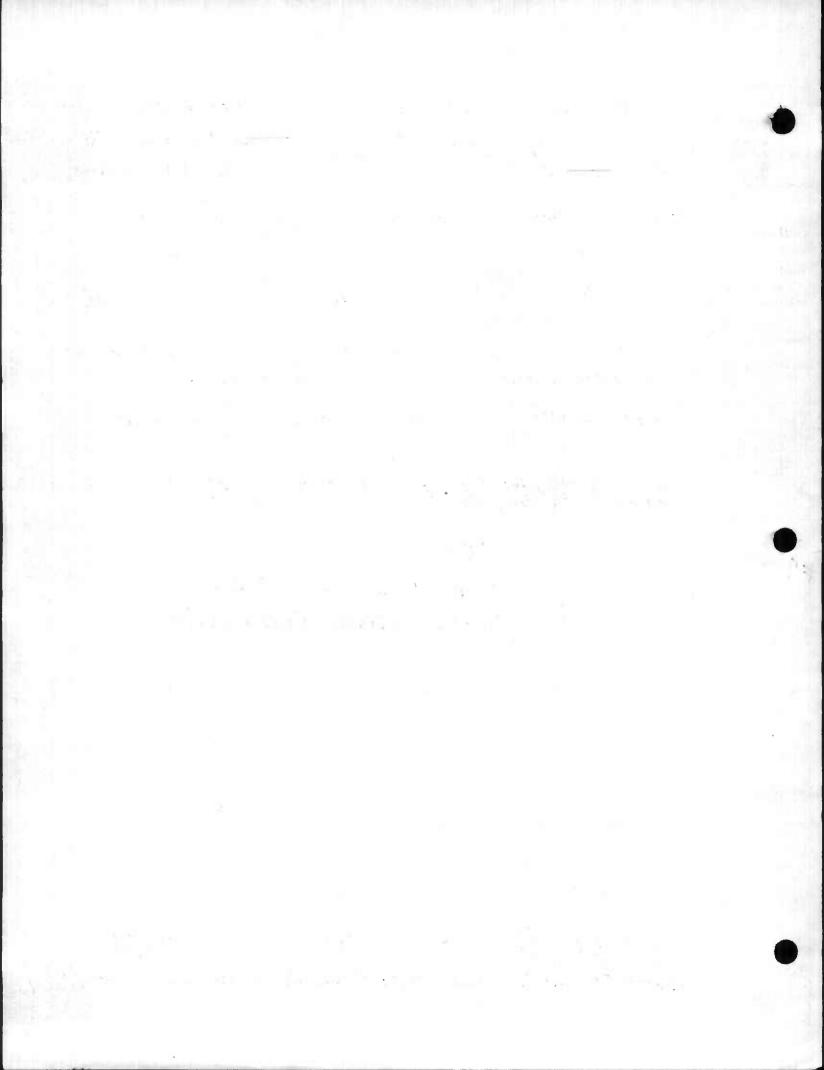
TAMES EBELING, MD 7401

29d. Date signed (Month, Day, Year)

22. Register Signature

OSLER DR. SVITEZOZ

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 5:05 am William M. Powell JUL 98 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner System 06 Maryland Medical Baltmore University If Under 1 Year Iff Under 24 Hrs. 8. Dete of Birth 5. Sociel Security Number 7. Age (In yrş. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 223-72-8016 1 M 2 F Months Days Director Usual Rasidance of Decedent the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a Stete 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar must be notified at Itimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Funerai death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritei Status permit. Pages 1 and 2 should be filed within 72 hours effer c Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural!. or han any injury or other traument. Bleck, White, etc. 1 ☐ Yes 2 No 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify py 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Dacedent's Education (Specify only highest grade completed) (Give kind of work done during most of working lifa. DO NOT use retired) Elamantary/Sacondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be 10 19b. Mailing Addrass (Street and Nymber or Ryral Route Number, City or Town, State, Zip Code) iQe. Informent/s Name/Raletionship (Type, 20b. Pleca of Disposition (Name of cemetary, crematory or other p Method of Disposition Date 1 Burial 2 Cremation 3 Removel from State 5 Other (Specify) 4 Donetion 21. Signature of Funeral Service Licana disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Myocardial Examiner Examiner or mary the burial-transit Sequentially list conditions, if eny, laading to immadiata cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es e consequence of) and Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): use as Pert if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco uss contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown been signed to should be deta Stage Renal Disease þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Was en eutopsy Completed hes 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No certificate or Attanding Physicien: T safter death. Il Director: After this certificat 25. Wes casa referred to medical examiner? Be 26. Placa of Daeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Nnpatiant 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28e. Deta of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accidant 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicida To the Hospital c within 24 hours at To the Funeral Di Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) P11796 July 13, 1998

Boltmore, MI)

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Pkuny

Registrar

State

30. Nema and eddrass of person who completed cause of death (Item 23a) (Type, Print)

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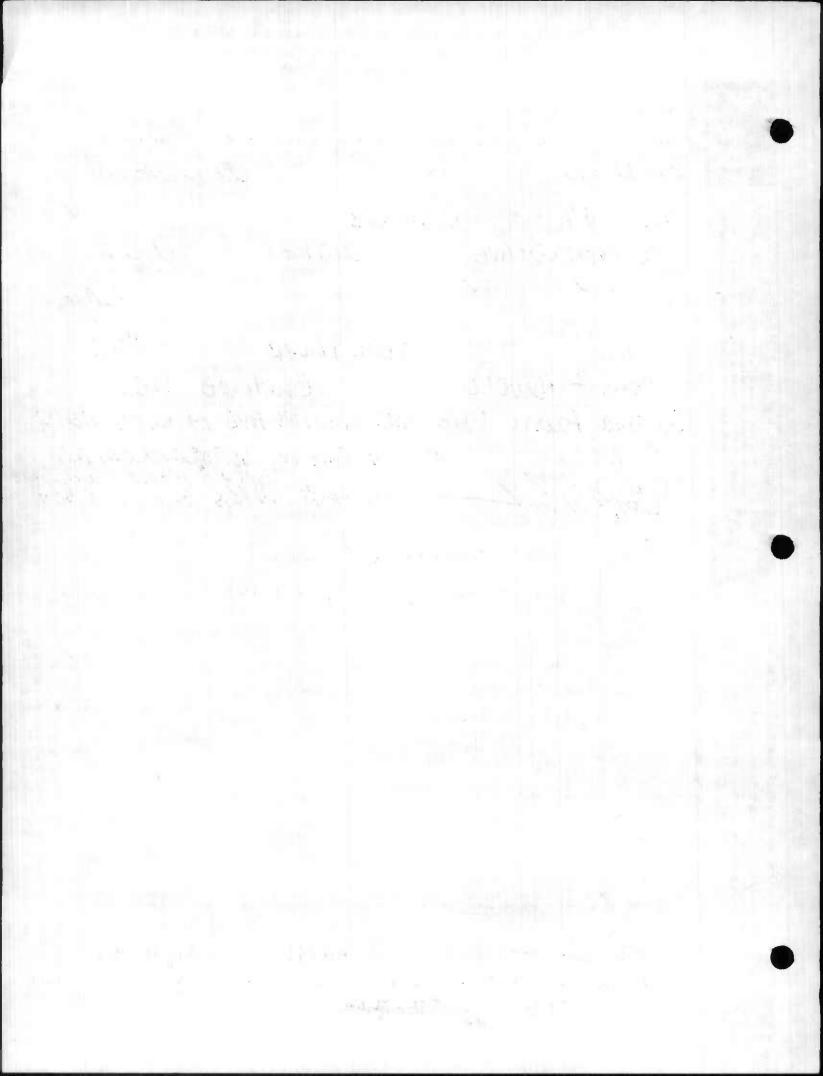
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31. Date filed (Month,

East University

32. Register's Signature

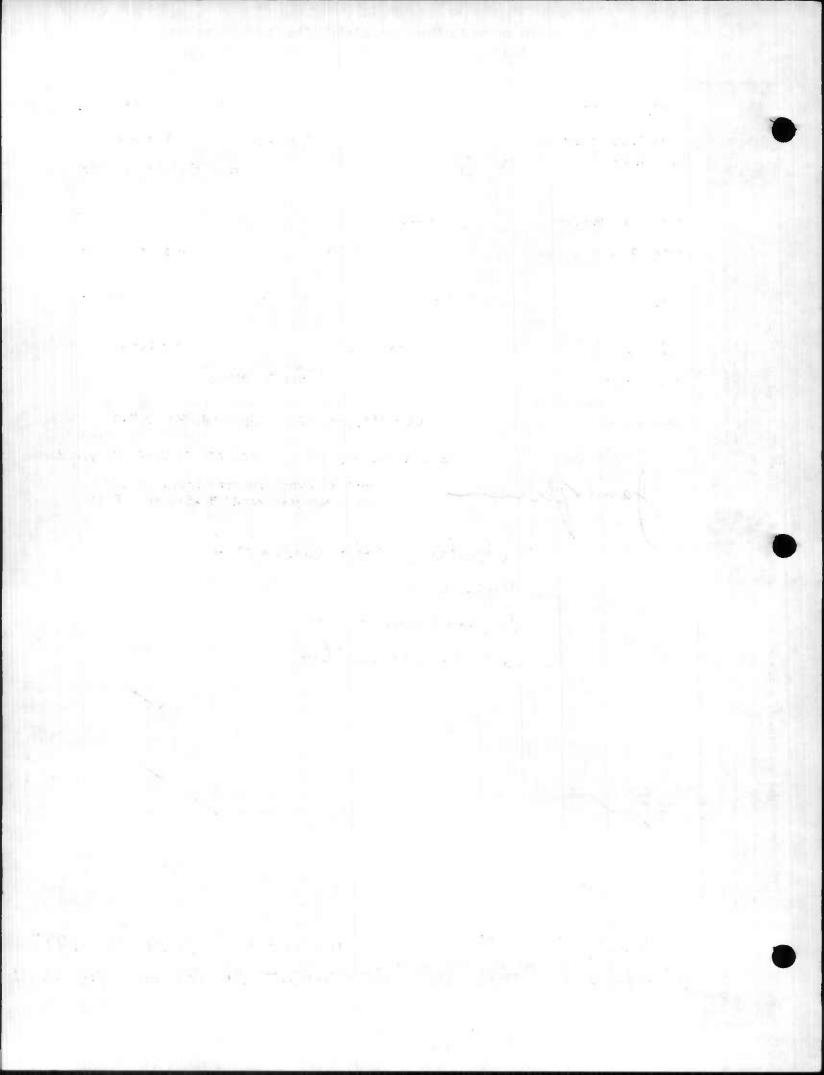
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 14, 1998 July 12:30 AM Evelyn M. Ruth /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1926 Chipper Drive Edgewood Harford If Under 24 Hrs. If Under 1 Year 8. Date of Birth Month, Day, Year) June 15,1912 9 Birtholace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 XX Months Hours Pennsylvania 86 Yrs. **Director** Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 vixes 2 □ No Director Maryland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21040 United States 1926 Chipper Drive death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: NO Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Example once. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White p No 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Wiker Enos Whitmer 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra Watts /daughter 1926 Chipper Drive Edgewood, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 7/15/98 Waldorf, Maryland Huntt Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 21. Signature of Funeral Service Li 20715 16000 Annapolis Road Bowie, MD implications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, only one cause on each line. Approximate Interval Between Onset and Death 23a Pr **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner attending physician and for use as the bunal-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Box 68760. certificate be Physician/Medical use as t 23b. Did tobacco use coptribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 3 signed t Division of Vital Records, by 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 has 1 Yes 2 No 1 Yas 25 No certificate director, 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) Lo 1 Yes / 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. fnjury at Work? 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Dey Year) Certification: After 1 Netural 5 Pending investigation Attending 1 Yes 2 No death. 2 Accident after death 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) in by 4 I Homicide 8 pelli Hospital 24 hours 29a, Certifier 1 Certifying Physicfan: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and manner stated. (Check only within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of Certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
M. JEDROEA C-PETERS, M.D. 104 19 CLUMTREE RD., BEL AIR, MD 24014 M. JEDRGEA 32. Registrer's Signature 31. Date filed (Month, Dey, Year) State JUL 171998 Julia Davidson - Mandall.

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 4c. County of Death 4b. City, Town, or Location of Death Neme (If not institution, give stree 8. Date of Birth Month, Day If Under 1 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Social Security Number Min Months 18M 20F Devs Hours 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 18 Yes 2□ No 10g. Citizen of What Country? 10e Str et and Number 10f. Zip Code Wes Decedent Ever in U,S. Armed Forces? 1 Dives 2 No If Yes, Give 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 Maritel Status 1 Never Merried 2 Married 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DONOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) dary (0-12) College (1-4pr 5+) 18. Mother's Neme (First, Middle, Maiden Sumame) DR1765 Il Route Number, City or Town, State, Zip Code) 19b. Mailing Address (St 20b. Pla 20w M 20c. Location - City o Town, Stete 1 Burial 2 □ Cremation . ⑤ Other (Specify) 4 Donation 21. Signature of Funeral Service License Approximate Intarval Batween Onset end Death disease Immediate Cause (Finel arter diseese or condition rasulting in daath) (oronar Due to (or as e consequanca of), Sequentielly list conditions, if eny, leading to immediate causa. Entar Undarlying Cause (Disaase or Injury thet initieled events resulting in death) Last Due to (or es e consequença of) Due to (or es e consequança of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to tha cause of death? 3 Probably 4 □ Unknown 1 Yes 2 No wellitus, adu 24b. Were autopsy findings avelleble prior to completion of cause of death? 24e. Wes en eutopsy 2 (20No 1 ☐ Yes 2 ☐ No 1 Yes rena tou 25. Was casa referred to medical axaminar? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify)

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29c. License number

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28d. Dascribe how injury occurred

28f. Location (Streat end Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Dey, Year)

1 Inpatient 2 ER/Outpetlent 3 DOA

28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28b. Tima of

28a. Data of Injury (Month, Dey Year)

Magaziner

32. Régistrar's Signeture

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Physician /Medical Examiner

Examiner

Physician/Medical

by

Be

1 ☐ Yes 2 No

5 Pending Investigation

6 Could not be datarmined

ONLE

27. Mannar of Death

1 Neturel

2 Accidant

3 Suicida

29e. Certifier

4 Homicida

29b. Signature and title of certifier

31. Date filed (Month, Day, Yeer)

Physician /Medical

Examiner

Funeral Director

by

Completed

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Funeral

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the Maryland

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Maryland 21215-0020

Baltimore,

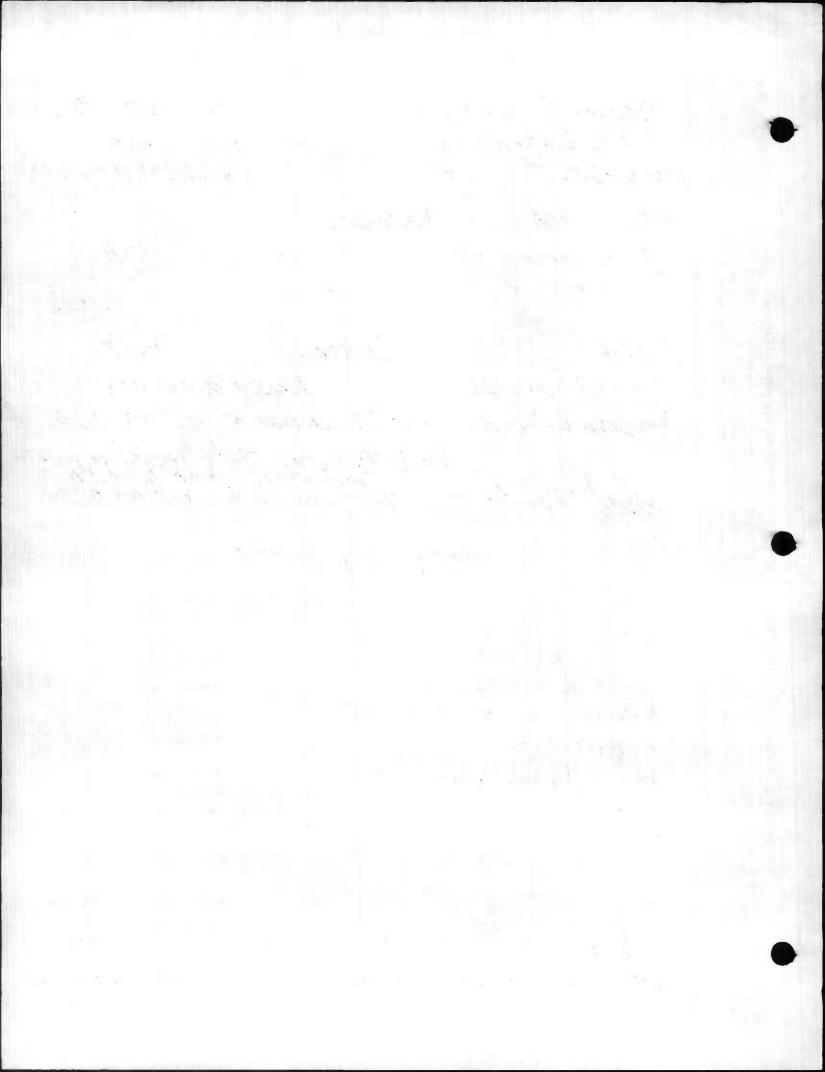
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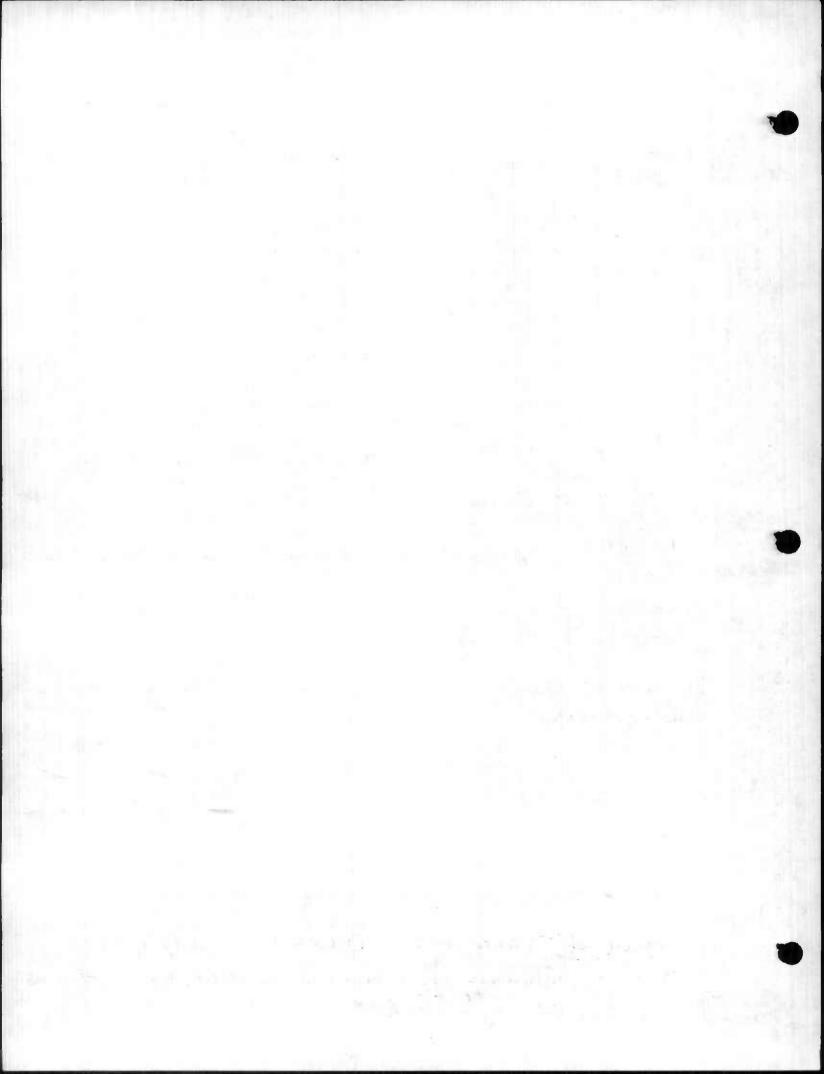
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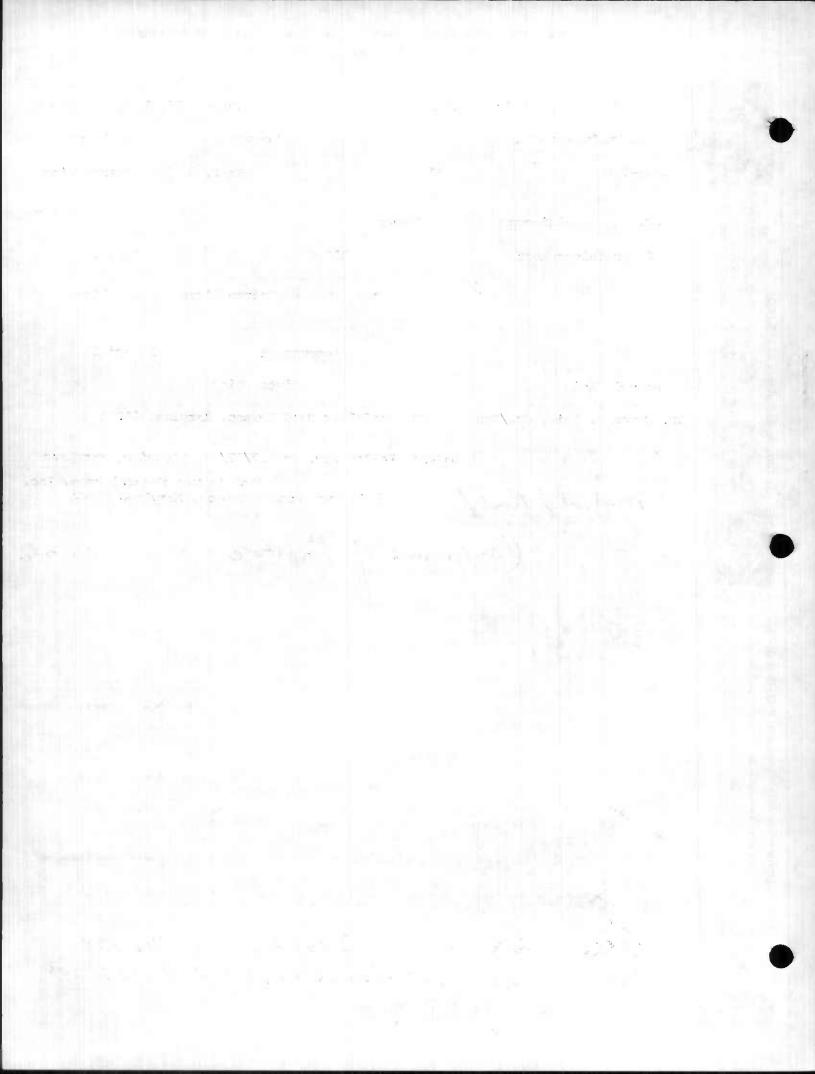


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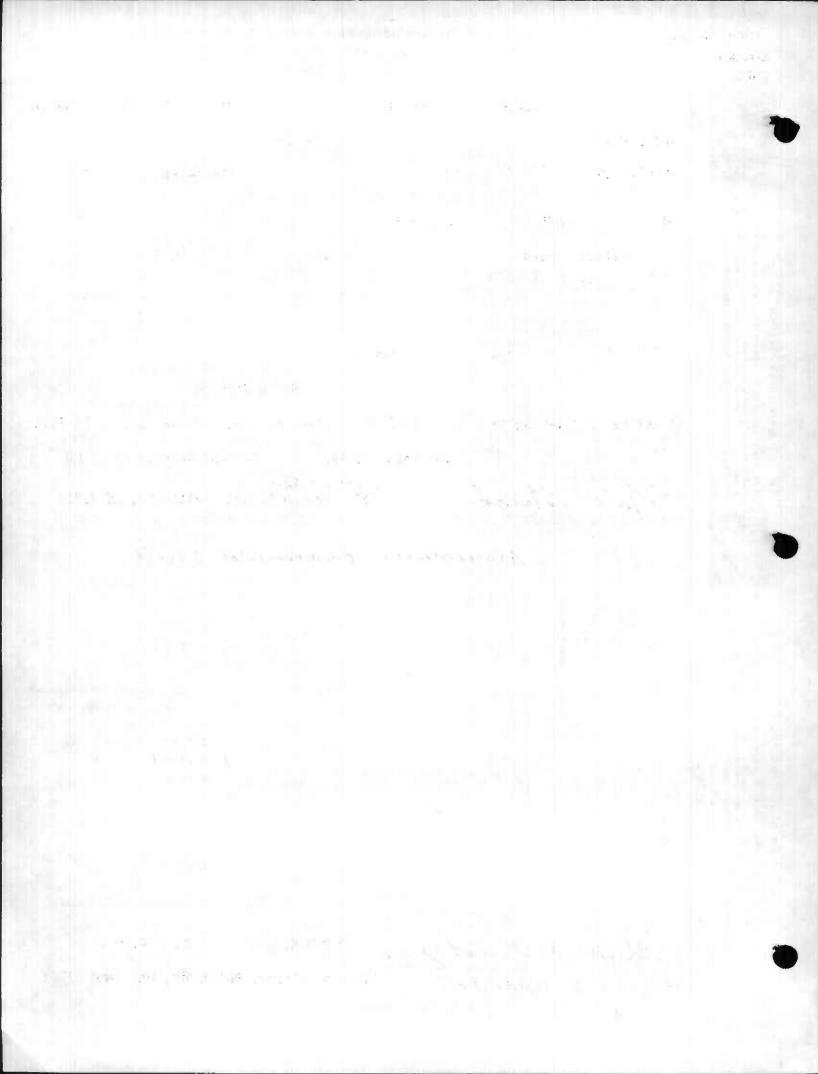
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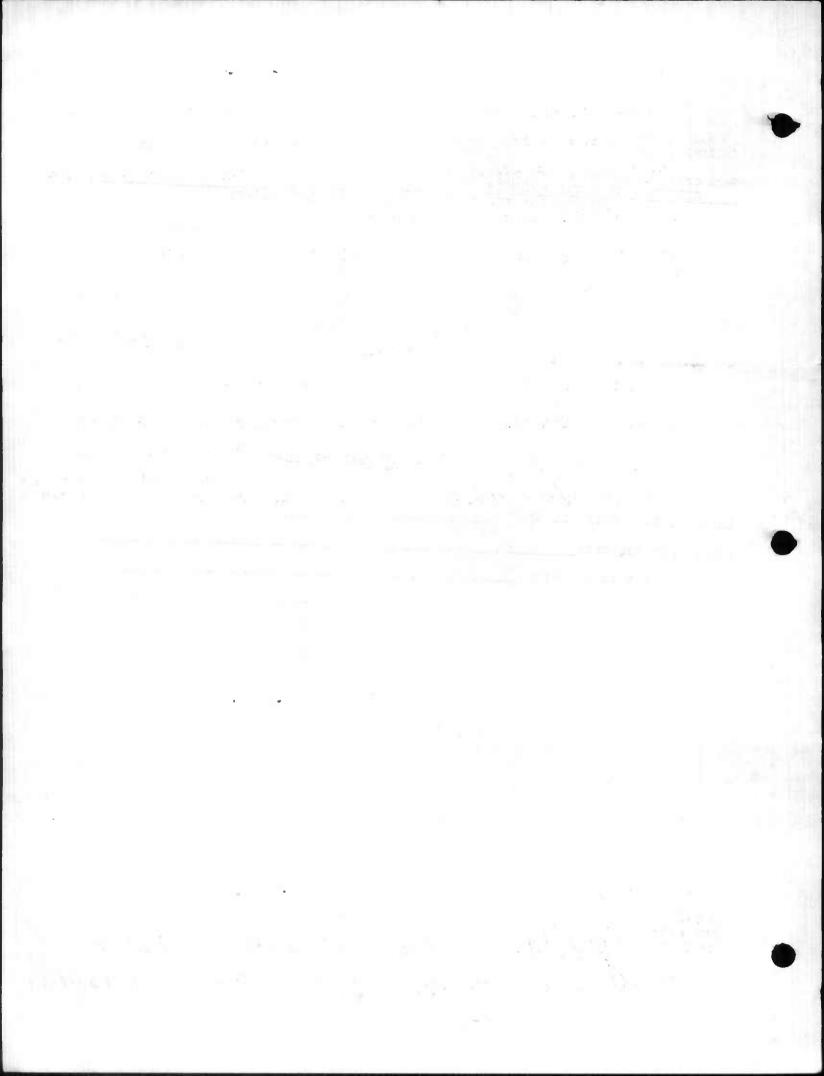


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To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicida 6 Could	ing (Mo ligation	onth, Day Yea	At home, farm, st	W	☐ Yes 2 ☐ No	28f. Location (City or To		nber or Rura	l Routa Number,
To the Hospital within 24 hours of To the Funeral is completely filled	edicai C		ng Phyaician: To the I Examinar: On the and ma								
Vithin 2 To the comple	M	29b. Signature and title of certifi	er			29c. Licer	nsa number		29d. Date sign		Day, Year)
H		Atysh 30. Nama and addrass of person	A M	use of death	(Item 23a) (Type	Print)	C.M.E.		JULY 14		1 01001
	tate	Stephen S 31. Date filed (Month, Day, Yea	, Rad	entz Algiquarsia Suna la	Ignature 73	111 Per	nn Street	t, Baltin	ore, Ma	arylan	d 21201
Regis	strar	JAL 71	1330								



<u>I</u> t	em#7	perFH,#27 per Phy G761 7/17		Certificate of			g. No.	1990
Physi /Med		Decedent's Nema (First, Middla, Last) Robert L. Schae	ffer			2. Date of Deeth Month	Dey Yaar	3. Time of Death 7:40 PM
Exam		4a. Facility Nama (If not institution, give street e 1027 Bentley Road	nd number)		4b. City, Town, or the Freela	ocation of Death	4c. County of Deeth	
Funera Directo		5. Social Security Number 6. Sax 1兒 M 20	7. Aga (In yrs. le:	st birthday) If Under 1 Yo Yrs. Months Da	ar if Under 24 Hrs.	8. Dete of Birth (Month, Day, Jan . 12	Year) 9. Birth	plece (State or Foreign intry) ryland
Maryland a-f show	tor	Usuel Residence of Decedent 10e. Stete 10b. County Maryland Baltimor		Town or Location Ceeland				10d. Insida City Limits 1 ☐ Yaa 2€060
th with the 23s or 28	Funeral Director	10e. Street and Number 1027 Bentley Road	'	10f. Zip Coo 21(1	g. Citizen of What Cou USA	intry?
1215-0020 within 72 hours after death with the Maryland ane. then "natural", or items 23e or 28e-f show the Medical Examiner must be notified at	b	1 Nevar Married 2 Merried 1 If You	a Decedent Evar In U,S. ed Forces? Yas 2⊠ No es, Give r or Detes:	13. Was Decedent If Yas, specity 0	of Hispanic Origin? (Sj Cuban, Maxican, Puarto No <i>Specify:</i>	pecity Yes or No- p Rican, atc.)	14. Race - Amari Black, Whita Specify: Wh:	atc.
	Completed	15. Decedent's Education (Specify only highast grada compi Elementery/Secondary (0-12) Coll	eted) ege (1-4or 5+)	16a. Decedent's Usuel Oc (Give kind of work do lifa. DO NOT use re Mechanic	cupetion ne during most of work tired)	king	8b. Kind of Business/ir Vending (
and be file dothe	To Be C	17. Fether's Neme (First, Middla, Last) Paul C. Schaeffe	r			na (First, Middle, Mil. Mille	-,	
Ma and 2 s alth or 27 is r trau	-	19a. tnforment's Neme/Reletionship (Type, Printers R. Schaef		19b. Meiling Address (Str 1027 Bent)				
Baltimore, Semit Pages 1 a Department of Hea moortant: if Nem	1	20a. Method of Disposition 1 Durial 2 Cramation 3 Ramoval 4 Donetion 5 Other (Specify)	St.	ca of Disposition (Name o natary, crematory or other John the emetery	place) Baptist	7 / 4 / 0 0	Oc. Location - City or T New Freed	
Balt permit. Depart imports any inj	MILITA	21. Signature of Feneral Service Lipersea	usteris	22. Nama and Ad			tenstein edom, Pa	Mortuary . 17349
Physician /Medica Examine		tmmediate Cause (Finel disass or condition resulting in deeth)	rostas	R Cause consequence of):		`	1 i	Approximata interval Between Onset and Deeth
X 68760, ertificete be executed ding physician and se es the buriel-transit	/Medical Examiner	Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last		s e consequence of):				
O. BOX edeath cert he attending ned for use	Physician/W	Pert tt. Other stgniftcant conditions contributing	to death but not result	ing in the underlying cause	given in Pert i.	23b. Dld tob	acco use contribute t	to the cause of death?
requires that the de seen signed by the a	by Phy				•	1 🗆 Ya	2 10 No 3 □ Pro	obably 4 Unknown
2 s t	Completed					24a. Wes en periorm	ed?	Vere autopsy findings vallabla prior to omplation of cause i death?
Vital Joint The Contificate rector, pa	o Be Co	25. Wes casa raferred to medical exeminer?			Other	th (Check only one		Yas 2 10
on of ing Phys Wher this unaral di	Certification: To	27. Menner of Death 1 Natural 5 Pending 2 Accident Invastigation 3 Suicide 6 Could not be	Dete of injury (Month, Dey Year)		njury et Work?	28d. Dascribe hov	oce 8 Other (Special Vinjury occurred Special Number or Rur	
Division To the Hospital or Attend within 24 hours efter death To the Funerel Director: /		4 Homicide	building, etc. (Specify)			City or Town,	State)	
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On and	the basis of examinetion mannar stated.	n and/or investigation. In n	ny opinion, daath occur	red at tha tima, dat	a and piaca, and dua	to the causa(s)
Twit of o		29b. Signature end iffin of certifier	m 10	NO D	33624	1 29	d. Date signed (Month,	Jay, rear)
		30. Name and address of person who completed John C. Downs	MD 75	os osler	DR. STE	504 To	owson, n	10 21204
S Regis	tate trar	31. Date filed (Month Day, Year) 1998	32. Registrar's Signatur	don-January				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** /Medical 4n Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 5. Sociel Security Number If Under 1 Year 7. Age (In vrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Birthplaca (Stete or Foreign (Country) **Funeral** Months Days Hours Min. 1⊠M 2□F -35 -28 Yrs. Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 1 ☐ Yes 2 No Funeral Director Maeulano or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 234 12. Wes Decedent Ever in U,S. Armed Forces? 1 10 Yes 2 □ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Meritel Stetus Peges 1 and 2 should be filled within 72 hours after nent of Heelth and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Ne 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: White Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Pleca of Disposition (Name of cametery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete CUU permit. Peges Department of H Important: If its any injury or of 1 Burlel 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility vans na BRd 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediete Cause (Final diseese or condition resulting in deeth) /Medical **Examiner** Due to (or as a consequence of): Physician/Medical Examiner 119. for use as the bundhhansit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es e consequence of): 2050/200/10 Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 ☐ Yea 2 ☐ No à Be Completed 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No director. 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending

The law requires that the death certificate be exec P.O. Box 68760. attending physicil sate has been signed by page 2 should be detact Records. this certificate Division of Vital Attending Physician: filled in by the funeral After death or Attend after death Director:

death

Maryland 21215-0020

Baltimore,

3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e, Certifier 29b. Signature and title of certifie

1 Yes 2 No

29d. Date signed (Month, Day, Year)

29c. License number

State

Registrar

completely

To the Hospital within 24 hours a To the Funeral C Hospital

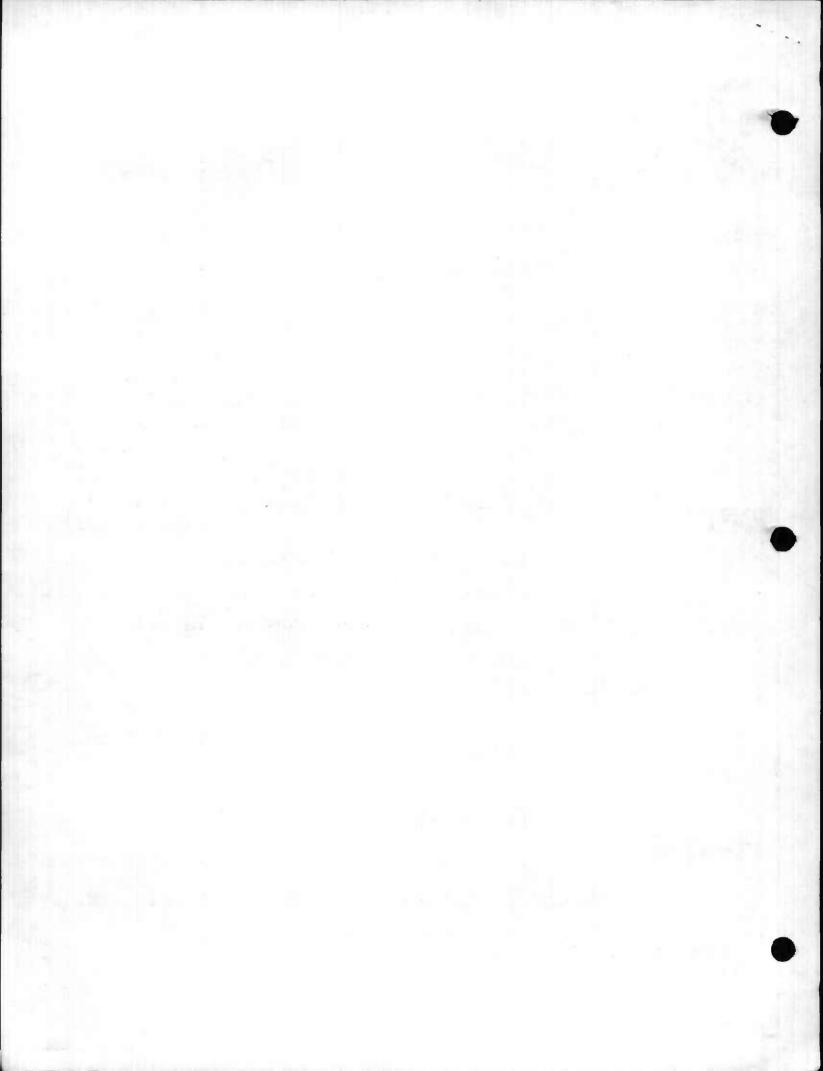
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

31. Dete filed (Mor#h, Dey, Year) JUL 17 1998

2 Accident

32. Register's Signature Gandelle.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

an cai	1. December 1 variety (* 1	irst, Middle, Las	11)					2. Dete of De			3. Time of Death
-	Robert How	ard Tho	mas					July	Dey 14	1998	3:15 PM
ier	4s Facility Name (If not	institution, give	street and number	7)			4b. City, Town, or	Location of Death			0,110
~~	305 E. Jop	pa Rd.					Towson	ı	Bal	timor	e
П	5. Social Security Numb		9x 7. A	ge (In yrs.	last birthday)	If Under 1 Yes			h y, Year)	9. Birthpli	ace (State or Foreig
	187-25-417 Usual Residence of Dec	1	W 201	61	Yrs.				18,1936		sylvania
1		b. County		10c. Ci	ity, Town or Lo	cation				10	d. Inside City Limits
5	Maryland B	altimor	e	T	owson						1 Yes 2 No
Director	10e. Street and Number			1		10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
	305 E. Jop	pa Rd.				21286			United	State	es.
	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U),S. 13. V	Ves Decedent of	f Hispanic Origin? (uban, Mexicen, Pue	Specify Yes or No	14. Raci	e - America k, White, e	
J	1 Never Married		1 Yes 2 X	No		Yes 2XN		ito i modifi, oto.y	Specify		
ŀ	3 Widowed 4 🛭		Year or Dates							WIII	
l	(Specify or	Decedent's Ed nly highest grad	ucation de completed)		16a. Deced	lent's Usuel Occ kind of work don DO NOT use reti	upation le during most of wo red)	orking	16b. Kind of Bu	isiness/Ind	ustry
ı	Elementary/Secondar 12	y (0-12)	College (1-4or	5+)	sales		,60)		automo	bile	
t	17. Father's Name (First	t, Middle, Last)					18. Mother's Na	me (First, Middle,			
I	Howard Tho	mas					Julia 1	Bishop			
1	19a. Informant's Name/	STATE OF THE PARTY	and the same of th		AND DESCRIPTION		et end Number or F	lural Route Number	er, City or Town,	Stete, Zip	Code)
1	Wallace Re	id/brot	her-in-la	WE	151 8	Stanmore	Rd. To	owson, M	21204		
ĺ	20a. Method of Dispositi		Damaual Imm State		Place of Dispo-	sition (Neme of netory or other p		Dete	20c. Location ·		
ı	1 Donation 5			Gr	reenmou	nt Crem	atory	7/17/98	Baltimo	re, M	aryland
Ī	21. Signature of Funera	Service Licen	500 117	7	22	. Name end Add	Iress of Fecility M	itchell-V	Viedefel	d Hom	e, Inc.
1	John &	Mal	shell +				6: B:	500 York	Rd. MD 21	212	
			Villa		Or as e conseq	lungograf):	6.0		4	1/	0 / 201 20
	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injurithat initiated events resulting in death) Last	ons, liate g	Нера	Due to (c		Hype	y Sy	udro	ne	(years Oyear
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